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Active versus passive therapist role in didactic psychotherapy with Nigerian clients

Azubike Felix Uzoka

Department of Psychology, University of Nigeria, Nsukka, Nigeria, West Africa

Summary. Findings concerning Western patients have consistently drawn attention to the fact that uncommunicative patients usually obtain less therapeutic gains and also evidence greater attrition rates. However, in African contexts, traditional healing practices generally prescribe a passive role for patients, while the healers assume the active role. This study examines the manner in which the verbal activity of the therapist affects the outcome of therapy in terms of patients' verbalization, attrition rate and the extent of patients' self-disclosure. The subjects of the study were 28 students and staff members referred to the University Psychological Services Centre with a variety of psychological problems. The subjects were randomly assigned to two treatment groups. In one group, the therapist was active (highly verbal and directive) and in the other he was relatively 'passive' (minimally verbal or directive). The results indicate that subjects in the group where the therapist was active evidenced greater verbalization ($P < 0.001$), attended more therapy sessions ($P < 0.01$) and evidenced greater self-disclosure than subjects in the group in which the therapist played a passive role. The results are interpreted as reflecting the need to evolve an 'active' process for initiating and sustaining the therapeutic alliance with African patients, because the active therapist role seems more consistent with the role expectations of clients in Africa. In effect, the therapist trained in the Western world needs to abandon the role prescription of relative 'muteness' emphasized in his training. Otherwise, his effectiveness is in considerable jeopardy.

Introduction

One of the problems confronting Western-trained psychotherapists in Africa is the seeming uncommu-

nicativeness of patients, which makes the process of didactic psychotherapy, at best, an arduous process. Kiev (1972) drew attention to this problem and Lambo (1972), in his studies of the Nigerian personality, observed a tendency towards extreme suspiciousness, a disposition which may be at the core of the observed uncommunicativeness. Together with the attendant avoidance of self-disclosure, this uncommunicativeness intensifies the problems inherent in attempts to apply Western psychological procedures in Africa, because it increases the chance of attrition among patients by limiting the possibility of evolving a therapeutic alliance between therapist and patient. This study examines an alternative that seems to offer promise in working with clients in Africa.

In traditional African therapy, it is the therapist (the native doctor - *Dibia*, *Babalawo*, etc.) who carries the burden of verbalization (Prince 1964). Usually he holds forth and describes the sources, origins and likely course of patients' problems. Generally, background information is obtained discretely from patients' relatives and the healer often acts as if such information is of secondary or minimal value in enhancing the effects of his ministrations. Undoubtedly, in severe emotional problems, the rantings of the patient must provide direct diagnostic clues. But the role expectations of both patient and healer reinforce the operational dogma that patients are not required to talk. Furthermore, silences are well-tolerated in African healing practices. During such silences, the native doctors are supposed to be communicating with 'higher forces', and patients and their families are not expected to disturb them.

However, in much of Western psychotherapy it is the patient who carries the burden of talking. Indeed, it has been determined that Western didactic psychotherapy is most effective with educated, verbal clients who can express themselves fluently and are able to assume that role in psychotherapy with mini-

mal difficulty (Goldstein and Simonson 1971; McNair et al. 1963). On the other hand, the less educated, non-verbal patients bring to therapy the opposite expectations and abilities and are often unable to obtain adequate benefits from the therapeutic experience. These kinds of patients often see themselves as relatively passive and, after stating their problems initially, take the position of "I am here because I want the doctor to do something to make me feel better" (Goin et al. 1965). In effect, these passive patients expect the therapist to be totally directive. Obviously, such expectation contradicts the norms and procedures of Western didactic psychotherapy.

In an African context, this problem assumes even more serious dimensions because of the prevailing beliefs in magic, omens, the supernatural and the power of divination. This state of affairs induces belief in the incapacity of the patient and underscores the need for an *intervener*, whose task it is to perform the appropriate rituals in order to alleviate the patient's symptoms. Indeed, Prince (1964), in his description of psychotherapy among the Yorubas, noted that there is much reliance on the suggestion of the healer's power and effectiveness and that he often communicates this power through 'direct commands', illustrative stories, songs, and by performing sacrifices for disturbed persons and their families. Under these circumstances, any attempt to suggest a participatory function for the patient or to induce self-analysis is likely to meet with profound resistance and failure.

Another confounding factor is what Professor Mazrui (1975) has called (in the context of African political behaviour) the "sage tradition", a traditional attitude that induces intense reverence for figures of authority. Mazrui observed that this reverence is often "hostile to the atmosphere of adequate intellectual independence" (p 397). In the context of psychopathology and psychotherapy, the therapist is seen as a figure of authority. Any suggestion that the patient's participation is sought would be unwelcome and might, in fact, dilute the placebo effect the healer's image normally engenders in African societies.

Furthermore, the success of Western medicine has not been too helpful in the evolution of psychological work in Africa. As Kiev (1972) noted, the magic of modern medicine in eliminating disease (e.g. yaws) speedily has created in the minds of most Africans a belief about Western medicine that is akin to the magical beliefs encountered in traditional African folk psychiatry. If penicillin can quickly eradicate disease, the patients will have difficulty in accepting therapy which insists that the elimination or management of a particular emotional problem re-

quires their active verbal involvement in the treatment process. In essence, the overall picture is that Western-type didactic therapy is, *ab initio*, unsuitable for use in African contexts because of the fundamental demand on the patient for meaningful verbal activity.

Empirical studies of verbal factors in psychotherapy have revealed that, where the patient is not substantially verbal, uncomfortable silences occur, often leading to the premature termination of therapy. In fact, Levitt (1966) found that drop-outs from therapy were silent more than three times as long in their initial interviews as those who stayed in therapy.

Interestingly, most outcome studies in psychotherapy have focused on the effects of the amount of patient verbalization on the outcome, particularly on attrition (e.g., Levitt 1966). Very little has been done to evaluate the effects of the verbal behaviour of the therapist on the outcome. Harari's (1971) notable study dealt with the variables in therapist behaviour that enhance the development of clients' trust in the therapist, and concluded that in order to retain some of his clients the therapist "must be directive, structured, limit setting, perhaps even omnipotent. Failing to do so, he will lose the patient's affection and thus jeopardize the entire therapeutic process" (p 133).

Apparently, unless the therapist trained in the west is willing to abandon the role expectations emphasized in his training and seek out new procedures, his effectiveness is in considerable jeopardy. As Giel (1978) observed, the inability of the clinician trained in the west to abandon the stereotyped prescriptions of the profession, often comes to stand between... (the therapist) and his patients" (p 93).

On the basis of Geil's review, with particular reference to the norms of folk psychiatry in Africa, the need for the assessment of therapist activity, particularly the therapist's verbal activity, seems paramount. Specifically, the study sought to determine whether the degree to which the therapist is verbal or non-verbal affects the outcome in terms of three variables: attrition rate, length of clients' verbalization and the extent of clients' self-disclosure.

Method

The subjects were university students and staff members who were referred to the University Psychological Services Centre with a variety of psychological problems. The subjects were randomly assigned to one of two groups (A and B) of 14 (12 males and 2 females). The mean age was 24 years for group A (range 20-35) and 23.8 years for group B (range 21-34). In order to use a didactic procedure, where

the therapist could have the option of talking elaborately or not talking, the rational emotive therapy procedure of Albert Ellis was adopted for both groups (Ellis and Greiger 1977).

For both groups, the therapist initially stated the goal of therapy. He told the clients (seen in individual sessions) that he would like to hear their problems and the for 2 of the scheduled 12 sessions, he would merely listen, to understand their problems fully. In actual therapy, however, the therapist remained relatively verbal in group A; in group B relatively non-verbal. The sessions were audio-taped.

As indicated, three measures of patients' behaviour were assessed, the first being the extent of patients' verbalization, which was assessed on the basis of the number of minutes a client talked during a session. Two independent assessors listened to the tapes and, using a stop watch, recorded the amount of time each client talked during a session. Where there was disagreement between the two assessors, they were required to reassess the tape in question. Generally, both assessors were in agreement as to the amount of time involved. The inter-rater reliability coefficient for the two assessors was 0.85 ($p < 0.05$). A second measure was the number of times a client attended the scheduled 12 weekly sessions.

The third measure was the amount of self-disclosure evidenced by clients. Self-disclosure was defined as the disclosure of significant (intimate) personal information (Cozby 1973) without any 'prodding' by the therapist. Self-disclosure has been positively correlated with liking (Jourard 1959). Furthermore, Jourard (1964) noted that the individual who does not disclose significant aspects of the self would be unable to establish close relationships with others, because large portions of the self may be seen as unwholesome and threatening and may, therefore, be repressed. Self-disclosing statements were collated by the two assessors, using indices already determined prior to the treatment process (e.g. statements about sexual involvement etc.). Any client producing three or more such pieces of significant, personal information spontaneously was rated high in self-disclosure, and any client producing less than three was rated low.

To ensure that the results obtained did not reflect differences in therapist style, only one therapist was used in both groups. However, in order to determine that the empathy level was the same for both groups, two independent assessors also assessed the tapes for empathy. The assessors reviewed six tapes randomly selected from each group. The exercise was to determine if any difference existed between the tapes in the degree of warmth and empathy demonstrated by the therapist. The degree of warmth and empathy

was judged to be similar for both groups. The inter-rater correlation for warmth was 0.80 ($p < 0.05$). Also, using the time the therapist talked as index, the therapist's verbal activity was judged by two assessors to be significantly different for the two groups.

After termination of the initial 12 sessions of the study, an effort was made to locate members of group B and to subject them to the therapy process used for the subjects in group A (verbal and directive role). The objective was to assess what changes, if any, would emerge as a result of the changed therapist role. Eight of the subjects were located and participated in this follow-up treatment.

For statistical analysis, the *t*-test was used. In assessing the differences in the dependent variables between the subjects in groups A and B, *t*-values were computed on the overall means for both groups. However, in assessing the difference between the two sets of conditions for the subjects in group B (BT₁ and BT₂), the *t*-statistic was computed using the differences between the paired scores of each individual subject under the two sets of treatment conditions (active and passive therapist role).

Results

The results of the study are presented in Tables 1 and 2.

The results indicate that subjects in group A, in which the therapist was relatively more active (verbal), attended significantly more sessions than subjects in group B(T₁), in which the therapist was passive ($t = 4.34$; $p < 0.001$). The results further indicate that when the subjects in group B were exposed to an active therapist role (BT₂), no significant difference was observed between the groups (A and BT₂) in the frequency of attendance ($t = 1.73$; $P < 0.12$). Also, the results indicate that there was a significant difference between the conditions in group B in that, when the therapist role was active (BT₂), the subjects attended significantly more frequently than when it was passive (BT₁; $t = 4.64$; $P < 0.002$).

Regarding the length of time talked by subjects during sessions, subjects in Group A showed significantly higher rates of verbalization than those in Group B when the therapist's role was passive (BT₁; $t = 3.00$; $P < 0.01$) and, to a lesser but significant degree, than the same subjects when the active therapist role was introduced in group B (BT₂; $P < 0.036$). Significantly, also, subjects in Group B under the active therapist role (BT₂) evidenced greater verbalization than when the treatment role for the same subjects was passive ($P < 0.02$). That is, when the performances of the subjects in group B under the two

Table 1. Frequency of attendance, amount of time talked and self-disclosure in subjects

Group	n	Therapist behaviour	Frequency of attendance	Amount of time talked (min)	Self-disclosers
A	14	active verbal role	mean 9.57 SD 2.65	mean 17.85 SD 7.97	10 71.42%
BT ₁ ^a	14	passive non-verbal role	mean 4.42 SD 3.45	mean 10.28 SD 5.64	4 28.57%
BT ₂ ^a	8	active verbal role	mean 6.87 SD 2.47	mean 11.50 SD 3.46	5 62.5%

^a T₁ and T₂ represent different treatment conditions for the same group of subjects. Group BT₂ has fewer subjects because of attrition

Table 2. Results of *t*-tests comparing the groups under two conditions of therapist behaviour

	Groups	No. of subjects	df	Mean difference	<i>t</i> -value	<i>P</i> (two-tailed) less than
A	A × BT ₁ ^a	14	13	5.14	4.34	0.001
Sessions attended	A × BT ₂ ^a	8	7	2.12	1.73	0.128
	BT ₁ × BT ₂	8	7	4.37	4.64	0.002
B	A × BT ₁	14	13	7.57	3.00	0.010
Minutes talked	A × BT ₂	8	7	6.75	2.59	0.036
	BT ₁ × BT ₂	8	7	4.12	2.99	0.020

^a T₁ and T₂ represent different treatment conditions for the same group of subjects. Group BT₂ has fewer subjects because of attrition

sets of therapy conditions were compared, the subjects evidenced greater participation (verbalization) when the therapist's role was active.

On the ratings on self-disclosure, ten subjects (71.4%) in group A, but only four (28.57%) in group B (BT₁) were rated as self-disclosers ($\chi^2 = 5.14$; $df = 1$; $P < 0.05$). However, when the active therapy role was introduced for group B subjects (BT₂), self-disclosure increased to 62.5% (5 of 8 subjects), as opposed to 28.57% when the therapist's role was passive.

Discussion

The results of the above study are consistent with findings by Auld and Eron (1953), Taulbee (1958) and Levitt (1966), in which reduction in attrition rate and even success in therapy was attributable to the verbal ability and participation of clients. However,

the present study also went further and demonstrated that the verbal behaviour of the therapist can induce increased verbalization and self-disclosure among clients. Several researchers have drawn attention to the role of pre-therapy training and modelling on the outcome of therapy (Truax and Carkhuff 1967; Truax and Warge 1969). The behaviour of the therapist in the present study may be properly described as 'in-therapy' training and reflects the effects of modelling on behaviour. Apparently, the clients in group A were induced to explore themselves and their affect and to become much more self-disclosing as a result of the therapist's behaviour. As in Van Der Veen's (1965) study using a client centred approach, this study also suggests that the therapist is an important source of variance regarding the outcome.

This study, in effect, suggests that there is nothing sacrosanct about therapist 'muteness'. Indeed, such a posture could be detrimental in working with clients in African societies at a time when every effort should be geared to establishing the credibility and effectiveness of psychotherapeutic procedures, especially of didactic therapies. However, two factors have to be borne in mind when the therapist assumes the verbal and directive role. Firstly, one must determine what the prerequisites are for effective performance in that role. Secondly, it would be appropriate to determine what dangers are inherent in the adoption of the 'active' role, particularly in African cultural settings.

The armour of the 'active' therapist

To be able to perform the feat of maintaining dialogue with some degree of face validity for the uncommunicative client, the therapist must be armed with enough information about the client's background in particular, and the total social milieu in general. Such cultural awareness is a necessary element in ensuring clinical sensitivity. Therefore, getting a good history is an essential aspect of pre-therapy activity. Also, the therapist must be cognizant of the patterns of developmental processes and peculiar attitudinal factors in the culture. For example, regarding developmental and personality factors, Lambo (1972) pointed out that the intense suspiciousness evident among normal Nigerian adults reaches its peak between the ages of 30 and 40 years. Such information is obviously an invaluable clinical asset. Such knowledge, together with social/familial information regarding each particular client, forms the core of material with which the therapist can engage in the initial stages of therapy. This gives the client time to become acquainted with the therapist,

to develop the ability to imitate his style and acquire the courage to engage in self-disclosure.

The therapist's discussions would involve a general appraisal of the kinds of problems a client with a particular background could be having. Obviously, it is necessary that the therapist who engages in this 'analytic' presentation at the beginning of therapy be well-informed about the circumstances of the patient, so as to evolve a meaningful appraisal and appreciation of the clients' difficulties, which are then communicated to the client in empathic dialogue. Apparently, this active role, which resembles the role of the native healer and is consistent with the traditional experiences and expectations of clients, seems more suited to African clients than the detached, non-verbal disposition of Western-type therapists.

Dangers in the therapist assuming the "active" role

There are inherent dangers in the therapist assuming the directive and verbally active role in the treatment context. One such danger is that, particularly with African clients, this role ascribes to the therapist the image of an all-knowing and omnipotent healer. It could also diminish the client's willingness to take responsibility for change and induce a posture of waiting for the all-knowing therapist to initiate and sustain the whole process of therapy. There is a danger, again especially in the African context, that this could lead to magical powers being ascribed to him; a situation which would further confound the effort to diminish the magical thinking that prevails generally, especially in pathological states. Indeed, Kiev (1972), has warned that where magical beliefs still exist, interpretations to clients must be carried out with caution "because there is a risk of reinforcing" these magical beliefs. Hammer (1968) has further observed that the nature of interpretation should vary according to the pathology of a patient.

Obviously, it is necessary to balance the therapeutic value of the placebo and stimulatory effect of the 'all-knowing' role with the danger of reinforcing the beliefs in divination and magic. One ploy is to ensure that once a therapeutic alliance is established, the therapist would quickly permit his own fallibility to emerge through shared experiences.

Finally, a considerable degree of clinical maturity and sensitivity seem desirable in order to ensure that the 'active' therapist is not carried away by his own seeming ingenuity. Otherwise, there is a danger that a neophyte therapist could easily mistake what is essentially a technique to facilitate patient participation for a way of solving the patient's problems. The objective should be to ensure that the ultimate responsibility for recreating and presenting the nature

of the prevailing difficulties and problems, within the context of didactic therapy, remains the task of the patient.

Conclusion

Western didactic psychotherapy places much emphasis on the ability of the patient to verbalize and participate actively in the treatment process. However, in traditional African folk psychiatry, the burden of verbalization is on the healer. In effect, the expectations of patients in Africa run counter to the role expectations in Western didactic therapy. Because of this role conflict and the noted uncommunicativeness of African patients, the process of didactic therapy would require some modifications if it were to be applied profitably. This study assessed the effects of two types of therapist role (active vs passive) on the performance of patients. The results suggest that the active therapist role induces greater patient verbalization, reduces the attrition rate and enhances self-disclosure among patients. These findings are interpreted as reflecting the need for the therapist trained in the west to abandon the role prescription of relative muteness emphasized in his training and to become more active. Apparently, this active therapist role, which resembles the role of the native healer, is more consistent with the traditional experiences and expectations of patients and seems more suited to the needs of African patients than the detached, non-verbal disposition of many Western therapists. It is, therefore, necessary to evolve therapy skills that would facilitate the active therapist role, so as to make the therapeutic alliance between therapists and patients easier, minimize attrition and enhance therapeutic gains.

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Dr. Azubike F. Uzoka
Department of Psychology
University of Nigeria
Nsukka
Nigeria
West Africa

The effect of social systems on group relations training

Edward B. Klein, Mary E. Correa, Steven R. Howe and Walter N. Stone

University of Cincinnati, Cincinnati, Ohio USA

Summary. Two Tavistock group relations conferences were held for mental health professionals in different social systems: a university and a medical school. Three-month follow-up studies were conducted. When compared with those attending the medical school conference, members of the university conference reported that they participated more in the application group and conference discussion, learned more in the intergroup event and about how the group effects task performance, that the emotional impact of the conference was greater, and were more likely to recommend the training to a friend. A social systems analysis of the conferences is offered as a way of accounting for these results. The conferences differed with regard to: 1. sponsorship, legitimacy and support of training activities; 2. heterogeneity of learning opportunities, an indication of systems openness and 3. authority and sentient linkages between members and staff. The more positive responses of the university participants probably had to do with multiple departmental sponsors, a heterogeneous environment, and outside authority and sentient ties. The less positive responses of the medical school members most likely were due to sponsorship by only one discipline, low systems openness, and a lack of sentient and authority linkages between members and staff.

There have been numerous reports describing group relations training for mental health professionals (Klein 1978). Follow-up studies indicate that members in these training events find them to be particularly useful in learning about work issues such as authority, leadership, followership, power, and covert group dynamics (Joseph et al. 1975). These authors suggest that one has to take into account the social system in which training occurs in order to fully understand the factors contributing to experientially-

based learning activities. One set of considerations includes the quality and extent of institutional support which provides legitimacy for this training and the availability of local role models for continuing application work. The Yale conferences studied by Joseph et al. (1975) were unique in that they had both full interdisciplinary endorsement and high status role models who used the theoretical approach of the conferences in both clinical and formal academic teaching. A second factor accounting for the influence of social systems on learning is prior social relations. Members and staff often knew each other either from formal work, authority relations and/or in a more social context. These social dimensions are termed sentient relations, meaning a connection of mutual choice and commitment not necessarily prescribed by institutional roles (Rice 1970). Conferences marked by high sentience often have an incestuous quality. The laboratory aspect of being away from real life ties is difficult to achieve when there are extensive connections between and among members and staff.

All of the above work has been based on Tavistock group relations conferences which are derived from the object relations perspective of Melanie Klein (1959) as explicated at a group level by Wilfred Bion (1959) and applied to organizations and social systems by Miller and Rice (1969). Tavistock training conferences are temporary learning institutions where participants are relatively free to study through experience. These conferences usually include in their design small self-study groups, intergroup exercises, application groups and discussion sessions. The first two are here and now events that allow members to learn experientially about small face-to-face groups and their dynamics, and about interaction between groups and the complexities of larger organizations. The latter two events provide more formal analytic discussions that permit members to integrate cognitive and affective levels of learning and to apply

the knowledge learned in the conference to the back home work situation.

Rioch (1977) has noted that the conferences reflect larger issues in the society and particularly developments in educational institutions. She identifies the intergroup event as a reflection of the more powerful, often covert, issues in the culture which are played out in the nature of the relationships between member groups and with the staff as a management group.

Despite the centrality of systems theory to the conferences, few investigations study the impact of the organizational context on the conference experience. The exceptions are the organizational works of Klein and Gould 1973; Miller 1980; and Miller and Gwynne 1972. None of the reports in the literature directly contrast group relations training in different systems. The present study focuses on this area of investigation by comparing training conferences with similar designs conducted in two different social systems in order to assess the impact of the setting on members' reactions, attitudes and learning.

Setting and methods

Two conferences sponsored by the Midwest Center of the A. K. Rice Institute were studied. Both were nonresidential and included the same training events with only minor variations in design (Correa et al. 1981). The university conference was the third one in the area and had interdisciplinary cosponsorship (Psychiatry and Psychology Departments, College of Education, and Office of Student Affairs). It was viewed as an additional training component in an urban, state university which had several ongoing group courses and training programs. The staff was predominantly local (four of the six consultants held positions of significant responsibility and were known by many members). The university conference was held on campus at a neutral site belonging to none of the disciplines and was therefore well bounded. The medical school conference was the first held in its area, was cosponsored only by a psychiatry department and was a different training vehicle than previously used. The four person consulting staff were strangers to the members and had no continuing relationship to the medical school. The Conference was held in the medical school itself which did not facilitate drawing a boundary between work and the training conference.

The first conference was held on the main campus of the university during a weekend in March 1978. Fifty-eight members attended. The second conference was held at the medical school on 2 workdays in May 1978. Thirty-nine members attended. The mem-

bers in both conferences were primarily in the mental health professions (psychiatry, nursing, psychology, and social work), although there were representatives from the fields of education, religion, and industry. At the medical school there were more members in significant faculty leadership roles than at the university conference, where members were students or trainees.

Since many of the people were busy professionals, a brief instrument was employed to collect data on 25 factors using a seven-point Likert-type scale. Members rated staff facilitation in three of the four training events: the small, intergroup and application groups. They then rated their own learning and participation in each of these events plus the conference discussion. Members also rated how much was learned in each of ten content areas: delegation of authority and responsibility, intergroup relationships, the use of personal power, group dynamics, principles of leadership effectiveness, principles of good followership, the role of unconscious or covert processes in small groups, organizational dynamics, effect of group process on task performance, and interpersonal problems in the exercise of leadership. Finally, members rated the outcome of their experience using four criteria: overall learning, emotional impact, desire to participate again, and recommending such training conferences to a friend. Questionnaires were mailed to participants three months following the conference to allow for decompression from the experience and integration of learning as has been reported in the literature (Bunker and Knowles 1967). Complete confidentiality was assured by the use of a separate postcard to designate informed consent.

Results

The percentages of members responding to the 3-month follow-up questionnaire were similar for both conferences; 62% (36 of 58) of university members and 67% (26 of 39) of the medical school conference participants returned their questionnaires. There were no differences in response by gender (68% of the men and 61% of the women completed the questionnaire).

As shown in Table 1, the university membership responded more positively than the medical school conference participants in most comparisons. On 6 factors there were statistically significant differences between the conferences, and on each of these the responses of the university participants were more positive. Members of the university conference participated more in the application group and conference discussion, learned more in the intergroup event and

Table 1. Means, standard deviations and significance differences of comparison factors between the university and medical school conferences

Comparison factor	University		Medical school		<i>t</i>	<i>d.f.</i>	<i>P</i>
	Mean	s. d.	Mean	s. d.			
I. Predictor variables							
Facilitation of:							
Small group event	5.22	1.40	4.47	2.07			
Intergroup event	3.91	1.79	3.41	1.60			
Application group	5.31	1.57	4.78	1.87			
Participation in:							
Small group event	5.83	1.16	5.67	1.41			
Intergroup event	4.50	1.66	5.04	1.34			
Application group	5.33	1.22	4.48	1.55	2.43	61	< 0.02
Conference discussion	3.47	1.81	2.44	1.50	2.39	61	< 0.02
II. Amount learned in:							
Small group event	5.08	1.38	5.00	1.59			
Intergroup event	5.17	1.66	4.19	1.69	2.30	61	< 0.05
Application group	5.09	1.60	4.38	1.58			
Conference discussion	4.06	1.69	4.07	1.77			
III. Amount learned about:							
Delegation of author	4.83	1.42	4.63	1.69			
Intergroup relations	4.71	1.27	4.63	1.64			
Use of personal power	5.64	1.29	5.00	1.36			
Group dynamics	5.42	1.34	4.85	1.66			
Principles of leader effect	4.42	1.50	4.33	1.54			
Principles of good follower	3.97	1.68	4.11	1.25			
Unconscious processes	5.22	1.43	4.78	1.53			
Organization dynamics	4.64	1.48	4.37	1.31			
Group effect on task	5.61	1.36	4.78	1.48	2.32	61	< 0.05
Interpersonal problems of leadership	5.47	1.28	4.96	1.68			
IV. Outcome criteria							
Overall learning	5.47	1.54	4.89	1.74			
Overall emotional impact	5.56	1.44	4.67	1.71	2.23	61	< 0.05
Desire to participate again	5.64	1.85	5.00	2.00			
Recommendation to a friend	6.03	1.25	5.04	1.89	2.50	61	< 0.02
		(<i>n</i> = 36)			(<i>n</i> = 27)		

about how the group effects task performance, reported the emotional impact of the conference to be greater, and were more likely to recommend the training to a friend. It should be noted that the standard deviations were higher for the medical school participants on 19 of the 25 measures. The probability that this would have happened if the two groups were really equally variable is less than 0.02. Such variability has been identified as a measure of transference in previous group research (Klein 1977).

Discussion

The literature suggests that Tavistock group relations conferences tend to be highly engaging activities. It is not unusual for participants to report the experience as being overwhelming, stimulating, not completely

understood and foreign in nature. These emotional responses should be reflected in how the members participate in the various events of the conference. Indeed members of both conferences participated similarly in the less structured, experiential here and now events – the small group and the intergroup exercise. However, the university members participated more in both the application groups and the conference discussion. These events occur after the completion of the here and now exercises, and are more traditional and familiar experiences. The sessions are used to review the conference and attempt to place it in a cognitive framework. The ability to participate more suggests that those in the university conference were less under the sway of intense group transference (Klein 1977) and were freer to make the transition from the experiential portion of the training to the discussion events.

One way of conceptualizing the differential findings is to consider the broader contexts, the social systems, in which the training occurred. The two conferences can be understood as taking place in settings that differ with regard to the following dimensions:

1. Sponsorship, or the legitimacy of training activities and how they are supported;
2. Heterogeneity of learning opportunities, an indication of systems openness or how willing an institution is to bring in new people and new ideas, and
3. Authority and sentient linkages, or how well members and staff know each other and their authority connections within the institutions where they work. With regard to each of these dimensions one can visualize a continuum ranging from most or strongest to least or weakest. At the extremes of this typology are incestuous and stranger conferences and in the middle the two conferences reported on in this study.

In terms of sponsorship, higher levels of organizational support and firmer contracts for such experientially-based learning activities may be associated with a greater sense of security (a more clearly bounded system), more realistic expectations (only a modicum of transference distortions), and greater likelihood of follow up. At one end are the Yale conferences where the staff who initiated the training had real life hierarchical authority over members. Such a conference may be seen as legitimizing participation since there is both status and political support for being a member. The university conference had a similar configuration of sponsorship. The conference was initiated and supported by high ranking interdisciplinary faculty and several then became staff members. These staff members taught the major group courses in departments from which most of the membership were recruited, had real life authority and legitimated participation in the training. In keeping with Singer et al. (1975) the university staff was committed and felt responsible for the training since there was both strong sponsorship and a working contract. This conference can be viewed as avuncular in nature.

The Medical school conference had a very different kind of sponsorship and support. Specifically, the female, non-physician professor who initiated the training had limitations to her status. The higher ranking and most organizationally powerful people at the medical school conference were members in contrast to being staff. One possible effect of a powerful group of high ranking physicians as members is the interaction of age and status on learning. According to Kolb (1974), the greater the age and accomplishment of people, the less their commitment to new learning.

Rogers (1960) has noted that new learning is negatively related to status in that high status members are often less open to explore new options.

Another factor which could account for learning differences was the opportunity for preparation and post conference discussions. At the university, the staff recruited, prepared and then conducted follow-up. In contrast, the weak medical school endorsement resulted in staff not performing pre and post-conference functions to enhance or consolidate learning.

The second dimension is systems openness as reflected in a heterogeneous environment. An indication of this dimension occurred in the intergroup event, which taps overt and covert institutional dynamics (Rioch 1977). The intergroup event is not replicated in any usual educational experience and is often startling in its impact. Until the start of the exercise, members have been in small face to face groups with a consultant always present. At the start of the intergroup event, the membership as a whole, a rather large unfamiliar group, has the task of forming some sort of political organization that would allow them to relate to various sectors within their own group and to the staff as a management group. Members in the intergroup event are not assigned to groups, rather the director defines the primary task – the study of group relations – to the total membership, who usually divide themselves to participate in the event. The process of breaking up and/or the formation of sectors is often experienced as traumatic. It was in this intergroup event that the university participants rated their learning as significantly greater than that of the medical school members.

In contrast to the university setting, the social system of the medical school was only overtly interdisciplinary and collaborative. Major interdisciplinary struggles were underway at the time of the conference. These were covert and unknown to the staff when the contract for the conference was negotiated. However, they later became front page news and resulted in the resignation of a Dean and many senior faculty.

The covert interdisciplinary struggle was reflected in behavior at the medical school conference where staff were assiduously avoided during the intergroup exercise. The members apparently recognized, consciously or otherwise, that the staff, which itself had an interdisciplinary composition, would expose and interpret conflicts with consequent potential for unleashing deeper schisms within the medical school system. There were no requests for consultation from the staff. As is more the norm, the staff were not avoided at the university conference. Indeed, they were requested as consultants to member groups which formed during the intergroup event.

Further support for the above can be seen in the differential learning reported-group effect on task (the only one of ten areas of learning in which a significant differential was found). Those at the university conference rated their learning higher than those at the medical school conference. Both the small group and the intergroup exercise clearly emphasize group effects on task, since in the intergroup event the medical school members could not utilize staff to further learning goals an important educational component was not fully utilized.

The two outcome criteria associated with statistically significant findings (overall emotional impact and recommending a conference to a friend) may be understood as positive reactions to staff as opposed to a more neutral position or resistance. Thus the lack of systems openness as expressed through a major interdisciplinary power struggle was reflected in the differential learning between the two conferences. At the medical school conference learning was restricted and conflicts were settled outside of the conference in a traditional fashion.

With regard to the third dimension, linkage, at one end are incestuous conferences where members know all of the staff and at the other are stranger conferences such as Tavistock modules at NTL (Klein 1978). The university conference had an intermediate linkage where many members knew some of the staff; i. e. there were some outside authority and sentient ties among staff and members. The medical school conference had another type of intermediate linkage: few of the members knew any of the staff which itself had high sentient ties, while members had high authority ties. What was lacking at the medical school conference was either sentient or authority linkage between members and staff. This configuration had the potential for great intergroup conflict between members and staff as shown by members avoidance of staff in the intergroup event.

Another factor which seemed of particular relevance contrasting the differences in learning during the two conferences was the covert meaning of the request for Tavistock training. Overtly, the university conference was based on greater experience and more realistic expectations whereas the training being new at the medical school led to heightened or unrealistic hopes. The university conference was held at the site where the director was a faculty member and staff taught major courses in groups. The covert meaning was to demonstrate within the university complex the value of this type of learning, and thereby retain the viability of the Tavistock enterprise in the midwest. Singer et al. (1975) note increased accountability when staff have a vested interest in the survival and the future of the work. The covert meaning of the re-

quest for the Tavistock conference at the medical school, although alluded to in the initial request for training, did not become apparent until data emerged within the conference itself. In retrospect, it appeared that within the medical school there was a fantasy that the serious conflict between disciplines, specifically medicine and nursing, would be alleviated somehow by providing an educational conference.

Frank (1957) and Arsenian et al. (1962) have written about the importance of cohesiveness and integral functions in small training and treatment groups. We posit that the more cohesive environment in the university conference led to a greater sense of sophisticated work pairing (Bion 1959) between a committed staff and interested members, which enhanced task performance and learning. In the medical school conference the intensity of the interdisciplinary rivalries led to greater resistance and anger. The staff uncomfortably interpreted a number of problematic issues that were interdisciplinary in nature in an environment which was assiduously avoiding the discussion of such conflicts. The interpretation of such covert phenomena heightened anxiety leading to a view of staff as disruptive strangers who were all too clearly highlighting systems issues that were better off being ignored. Under these conditions high status members (physicians in particular) found the approach offensive, as suggested by an analysis of reactions by discipline. A fight stance (Bion 1959) evolved between members and staff. As noted by Arsenian et al. (1962), real conflicts are often projected onto leaders in order to maintain the small group, and in this case, the larger social system. The lack of cohesiveness and difficulty in functioning in the staff was expressed in a variety of ways: the director did not feel fully authorized; one consultant was withdrawn and the other two requested "combat pay". Thus, a covert goal to solve interdisciplinary problems could not be reached, instead the conflicts were avoided during the conference. The staff felt the pressures, and the conflicts within the medical school were dealt with in the more traditional ways.

It is clear in retrospect that the dimensions of sponsorship and linkage are themselves related. Knowing some of the staff, having real authority relations, staff availability and institutional support which legitimizes such training, enhances the members' abilities to feel secure enough to learn. The Yale conferences demonstrated greatest authority and sentient linkage, heterogeneous environment and sponsorship; previous reports (Joseph et al. 1975) suggest that members at such conferences learned a great deal. The medical school conference had little authority and sentient linkage between staff and members, the least heterogeneous environment and only pro-

vided partial endorsement. Members did not experience the training as consistent with the goals of the institution. Interpretations of systems issues (conflict between disciplines and more covertly, issues of gender and race) may have been experienced as an affront. Though only a small percentage of the members (mainly the organizationally most powerful ones) may have felt this way, they most likely influenced the whole conference culture. We propose that a combination of covert wishes to maintain the status quo and not resolve interdisciplinary conflicts plus the effects of weak support led to greater resistance, more transference reactions, less participation and a less positive view of the conference. This was further confounded by the lack of strong staff commitment to the enterprise.

Further research regarding the effect of authority and sentient linkages and other systems dimensions upon learning in different settings appears in order, since the present results may be confounded by conference size, status and age of members. This would represent a shift in our views that such linkages are obstacles to be overcome to a more positive possibility that they may facilitate learning. It is of interest to note that the university conference, which had partial authority and sentient linkage, some heterogeneity and fairly strong sponsorship, led to a more collaborative environment which facilitated the primary task of the conference-learning. Since most of the members came from departments where teachers focused on the relationship between behavior and task, there seems to have been a greater commitment to the learning goals of the conference. It may be that falling in the middle on these important systems dimensions makes an institution more amenable to experientially based learning.

Finally, Miller (1980) has noted the importance of the political dimension in group relations training and consultation. It is just this larger political perspective which needs to be integrated into our training models if such educational activities are to aid mental health professionals in their everyday work in a constantly more complicated and changing society.

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Prof. E. B. Klein
Department of Psychology
University of Cincinnati
400c Dyer
Cincinnati, OH 45221
USA

Influence du mode de paiement sur la demande de psychothérapie

Comparaison entre les clientèles de psychanalystes, d'un psychiatre conventionné et d'un centre gratuit dans la région parisienne

V. Kovess¹ et A. Buras-Eisenberg²

¹Ancienne Interne C. H. U., Universitaire McGill, Montreal, Canada et ²Institut de Psychiatrie la Rochefoucauld, Paris, France

Summary. A comparative study is reported of three groups of patients receiving psychoanalytic care in different settings in Paris: these comprised (a) a center which provided free therapy (86 patients), (b) private care, the cost of which was reimbursed through a system of national insurance (30 patients) and (c) private care paid for by the patients (100 patients). The clientele were grouped into categories in terms of income, education and profession. Those with the lowest income went to the free center, those with the lowest educational level went to the reimbursed care system, while the private psychoanalysts saw the patients with the highest relative income and education. The goals and insight of the patients were found to be similar in all groups. There were more early drop-outs when patients did not pay their analyst themselves. Free or reimbursed care systems are effective ways of providing psychoanalytic psychotherapies and to a wider clientele than in the private system. The free center was not effective in providing psychoanalysis. Factors such as goals and expectations of patients, which are not social ones, must nevertheless be taken into account.

Résumé. Dans cet article les auteurs comparent trois groupes de patients recevant des soins psychanalytiques dans trois contextes différents: Un centre dans lequel les thérapies sont gratuites (88 patients) un psychiatre conventionné dont les soins sont remboursés par la sécurité sociale (30 patients); des psychanalystes que les patients payent eux-mêmes (70 patients). La demande des patients a été considérée tout particulièrement. Le traitement proposé aux patients et le devenir sur six mois ont également été analysés. Les résultats montrent que: 1. Les trois clientèles forment trois groupes distincts définis par leur revenu, leur éducation et leur profession. Les patients qui ont les revenus les plus bas, consultent au

centre gratuit et ceux qui ont fait le moins d'étude, auprès du psychiatre conventionné. Les psychanalystes privés voient les patients à la fois les plus riches et les plus instruits. 2. Les objectifs et le degré d'insight des patients sont identiques dans les trois groupes. 3. Le nombre d'abandons précoces est plus élevé lorsque les patients ne paient pas eux-mêmes leur analyste. Les auteurs concluent que les systèmes de soins gratuits ou remboursés élargissent la clientèle des psychothérapies psychanalytiques mais non celle des psychanalyses et qu'il ne faut pas négliger l'importance de facteurs autres que sociaux, en particulier les objectifs et les attentes du patient.

Nous présentons ici une comparaison entre la clientèle faisant une demande de psychothérapie à l'Institut de Psychiatrie La Rochefoucauld, auprès d'un psychiatre conventionné¹ et auprès de psychanalystes, psychiatres ou non, payés en totalité par leurs patients.

Cette comparaison fait suite à une étude sur la première demande, à l'Institut de Psychiatrie La Rochefoucauld, publiée dans ce même journal en janvier 1980.

L'ouverture de centres financés par des organismes publics, offrant des psychothérapies ou des analyses devrait permettre l'accès à la psychanalyse et à ses applications, de tous ceux qui en étaient exclus par leur coût élevé.

¹ Il existe en France un système d'assurance maladie obligatoire prélevé directement sur le salaire des employés et étendu à presque toutes les catégories sociales: la Sécurité Sociale. Cet organisme d'Etat négocie avec les praticiens des «conventions» grâce auxquelles les patients peuvent être remboursés de leurs soins à 80% et même à 100%.

La comparaison des clientèles respectives d'un centre gratuit avec celles de psychanalystes exerçant dans le privé, ainsi que la comparaison des services qui leur sont respectivement offerts, permet d'évaluer dans quelle mesure l'ouverture de ces centres gratuits a corrigé l'inégalité d'accès des différentes classes sociales aux applications de la théorie psychanalytique. Cette comparaison permet également d'évaluer quels facteurs autres que l'argent interviennent dans l'accès aux applications de la psychanalyse et de mesurer l'importance des éléments culturels, en particulier de l'éducation.

Intérêt de ce travail

Les études quantitatives concernant les soins psychiatriques externes, en France, sont peu abondantes. Une partie de ces soins sont distribués par les dispensaires d'hygiène mentale. Il s'agit d'établissements publics, sectorisés et gratuits, qui fonctionnent surtout comme des établissements de post-cure des hôpitaux psychiatriques. Ils reçoivent essentiellement des patients psychotiques et/ou alcooliques, peu instruits, de milieu socio-culturel bas, auxquels les traitements proposés sont le plus souvent chimiothérapiques ou institutionnels. Le secteur doit répondre aux besoins «d'hygiène mentale d'une population donnée» et a un rôle plutôt «social». C'est le secteur, qui a été le plus étudié sur le plan statistique (Bonnafe 1978).

Une autre partie des soins psychiatriques externes est distribuée par le système de soins privés, au sujet desquels les données empiriques sont plus rares. On sait, cependant, que les généralistes voient un pourcentage élevé de patients présentant des problèmes émotionnels (74%) et que 10% de leur pratique ne concerne que la psychiatrie (Monnier 1980). Les activités des psychiatres privés n'ont pas été très étudiées. Quant aux psychanalystes, leurs préoccupations et leurs travaux se situent davantage dans le champ théorique et clinique. Il n'existe pas de liste permettant d'évaluer l'activité psychanalytique en France car l'exercice de la psychanalyse n'implique pas obligatoirement d'appartenance à une corporation ou à une école (il y a plusieurs écoles ou sociétés de psychanalyse françaises).

Enfin, il existe des structures intermédiaires entre les systèmes public et privé: ce sont des centres privés ayant des contrats avec le Département des Affaires Sanitaires et Sociales (D.A.S.S.) et qui offrent des soins gratuits. Certains de ces centres ont des conventions directes avec le secteur (Maltaverne et Balvay 1980). D'autres, non. Le centre dans lequel a été réalisé une partie de ce travail n'est pas sectorisé.

Constitution de l'échantillon et procédures utilisées

A l'Institut, tous les patients qui font une demande au service d'accueil soit par écrit, soit par téléphone, reçoivent une lettre leur proposant un rendez-vous pour un premier entretien, tenant compte de leurs disponibilités horaires. A partir de janvier 1978, les patients ont été exclusivement vus par trois évaluateurs faisant partie de l'Institut: un psychiatre, un psychologue et un interne (les renseignements administratifs étant toujours recueillis par une secrétaire de réception).

Ce premier entretien était présenté comme un entretien d'information réciproque. Il était précisé d'emblée aux patients que la personne qui les recevrait, ne serait pas leur thérapeute par la suite, mais qu'elle était là pour recevoir et préciser leur demande et les orienter.

Dans le privé sept analystes ont considéré pour la recherche tous les nouveaux patients qui leur faisaient une demande, à partir d'une date donnée jusqu'à ce qu'un échantillon de 100 patients soit constitué. L'entretien était un entretien préliminaire habituel, suivi ou non d'une prise en charge par l'analyste qui avait fait l'entretien. Les analystes qui participaient à cette recherche avaient tous une pratique en Institution en plus de leur pratique privée; certains exerçaient dans l'Institut La Rochefoucauld. Ils avaient donc tous l'expérience de différentes clientèles.

Seuls les patients faisant une demande pour la première fois, à l'Institut La Rochefoucauld ou auprès des analystes, ont été considérés. Pour des raisons éthiques et méthodologiques, l'enquête s'est basée sur le premier entretien que l'on s'est efforcé de maintenir semblable à un premier entretien habituel.

Les entretiens étaient notés in extenso en écriture rapide par les analystes et revus immédiatement après l'entretien. Tous les cas étaient présentés, soit à la réunion d'évaluation de l'Institut où tous les points du diagnostic, de la demande et de l'indication étaient discutés, soit à une réunion semblable tenue avec les analystes concernés. Les entretiens étaient codés lors de réunions par les mêmes psychologue et psychiatre, qu'il s'agisse des patients vus en privé ou des patients de l'Institut.

De plus, tous les cas ont été revus par des psychiatres extérieurs à la recherche. La méthode, tant en privé que dans l'institution s'est beaucoup inspirée du modèle analytique. L'entretien, peu directif, laissait le patient exprimer sa demande.

Les données recueillies comportaient des renseignements socio-économiques: lieu d'habitation, profession et situation professionnelle (chômage, arrêt maladie), revenu, niveau d'instruction etc... La

demande était étudiée suivant le schéma proposé par Lazare (1975) c'est à dire une prise en compte spécifique de la souffrance, des buts désirés par le patient et des moyens qu'il compte mettre en oeuvre pour parvenir à les réaliser. Les diagnostics ont été établis à partir de la symptomatologie exprimée, et classée suivant le D.S.M. III. Les modalités de prise en charge ont été divisées en entretiens; psychothérapies; ou analyses. Le devenir immédiat, et à moyen terme: six mois, un an de ces patients a été vérifié auprès des thérapeutes.

Resultats

Description de l'échantillon

L'échantillon étudié se compose de sous-échantillons au nombre de trois, soit:

100 patients vus à l'Institut (88 demandes de «psychothérapies», 12 «autres»)

70 patients vus par les analystes privés n'acceptant pas le remboursement par une assurance

30 patients vus dans le privé par un psychiatre «conventionné» c'est à dire remboursé par l'assurance maladie.

Attendu qu'il s'agit de tester des hypothèses ayant trait à la demande de psychothérapies et que les patients qui consultaient à l'Institut pouvaient formuler des demandes autres (médicaments, service social, relaxation), nous avons exclu ces patients de nos analyses. Ceci paraissait d'autant plus justifiable que ces patients sont, somme toute, très peu nombreux (12%). Il apparaît donc clairement que l'Institut La Rochefoucauld est perçu comme un lieu où se font essentiellement des traitements psychothérapiques, ce qui correspond d'ailleurs au personnel employé par l'établissement.

Les demandes dites «autres» concernant les psychiatres exerçant dans le privé, auraient pu inclure des patients demandant des médicaments; en fait, aucun patient ne figure sous cette rubrique car les psychiatres exerçant dans le privé n'ont considéré pour la recherche, que les patients demandant une aide basée sur la parole.

La population finale retenue pour la recherche comprend donc 188 patients ayant fait une première demande d'un traitement de type psychothérapique dans l'un des lieux considérés.

Modalités du traitement des données

Nous avons analysé les données suivant trois axes: la comparaison des trois sous-échantillons, la compa-

Tableau 1a. Sexe des patients

Lieu	Femme	Homme	Total lignes
Elan	54	34	88
Privé	49	21	70
Conventionné	20	10	30
Total colonnes	123	65	188
$\chi^2 = 1.31$	d.d.l. = 2	ns	

Tableau 1b. Age des patients

Lieu	> 40 ans	30-40 ans	20-30 ans	< 20 ans	Total lignes
Elan	16	21	46	5	88
Privé	6	26	35	3	70
Conventionné	6	9	11	4	30
Total colonnes	28	56	92	12	188
$\chi^2 = 9.32$	d.d.l. = 6 ns				

> 40 ans ***** (28) 14.9%
 30-40 ans ***** (56) 29.8%
 20-30 ans ***** (92) 48.9%
 < 20 ans ***** (12) 6.4%
 Population totale $n = 188$

raison des patients vus en privé avec ceux vus en public, la comparaison des patients payant, avec ceux ne payant pas ou remboursés (quel que soit le lieu, public ou privé).

Statistiques descriptives: comparaison des trois clientèles

Résultats sociologiques

Démographiques: Quel que soit le lieu et le type de pratique considéré, les patients ont en moyenne le même âge (âge moyen: 30 ans) et comportent une majorité féminine (65.4%) (Tableau 1).

Le lieu d'habitation varie considérablement avec l'endroit où est faite la demande: la clientèle de l'Institut se recrute partout: la moitié habite en banlieue parisienne, parfois lointaine, et seuls 14% habitent à proximité de l'établissement. Par opposition, le recrutement de la clientèle du psychiatre conventionné s'effectue à 80% sur la base d'une proximité locale (une banlieue). Les analystes ont une clientèle parisienne (73%) et ne recrutent pratiquement pas sur une base de proximité locale. Un certain nombre de leurs patients viennent de la province.

Ces différences très significatives concernant les lieux d'habitation et les patterns de recrutement, témoignent d'emblée de différences sociologiques importantes, car le fait d'habiter Paris intra-muros ou la

banlieue, correspond à des situations sociologiquement différentes. Le choix d'un psychiatre sur une base géographique témoigne d'un pattern de clientèle «médicale», comme celle des généralistes (Tableau 2).

Professions: Comme on pouvait s'y attendre, la répartition des professions n'est pas égale dans les trois sous-échantillons. Cette répartition est encore plus différenciée, suivant l'axe payant/gratuit ou remboursé, que suivant l'axe privé/public. Les ouvriers sont très peu nombreux (2.7%) et pratiquement, tous vus à l'Institut. Les employés représentent respectivement 40% et 36.7% de la clientèle recevant des soins gratuits ou remboursés, tandis que les professions libérales sont presque toutes vues dans le contexte privé non remboursé.

Une remarque peut déjà être faite: les cadres moyens représentent le tiers de la clientèle du psychiatre

conventionné et seulement 21.4% des analystes privés; par contre, les enseignants constituent une grande partie de la clientèle des analystes (41.4%). Les enseignants ont des revenus plutôt inférieurs à ceux des cadres moyens, mais représentent une population plus informée. Ceci prouve l'importance des facteurs culturels dans le choix du lieu de psychothérapie (Tableau 3).

Situation professionnelle suivant les items: Travaille, au chômage, à la retraite, en arrêt de maladie court ou long.

Les résultats sont à la limite de la signification et les différences n'apparaissent que lorsque l'on considère les trois lieux de pratique. En effet, le sous-échantillon de patients vus à l'Institut, bien qu'il soit en majorité composé de travailleurs (69%) comporte 31% de gens dans des situations «autres», tandis que le sous-échantillon recevant des soins remboursés comporte un pourcentage nul de cette catégorie. Le sous-échantillon vu en privé est intermédiaire et composé de patients qui, dans 77.5% des cas, travaillent. Dans l'ensemble les patients qui entreprennent une psychothérapie payante ou non, ont une activité professionnelle (Tableau 4).

Niveau d'études: Il a été mesuré par les diplômes obtenus au cours du cursus scolaire et universitaire, il est très différent selon que les patients payent ou ne payent pas les soins. Une bonne majorité des patients faisant ou ayant fait des études supérieures (62%) se

Tableau 2. Domicile des patients

Lieu	Proximité	Paris	Banlieue Province	Total lignes
Elan	12	34	42	88
Privé	2	51	17	70
Conventionné	24	2	4	30
Total colonnes	38	87	63	188
$X^2 = 98.07$	d.d.l. = 4	$s = 0.0000$		

Tableau 3. Professions des patients

Lieu	Personnel de service, ouvriers	Employés	Sans profession (mère de famille)	Artisans, artistes	Cadres moyens	Etudiants	Enseignants	Professions libérales	Total lignes
Elan	4	36	1	6	14	12	11	4	88
Privé	0	7	1	2	15	29	2	14	70
Conventionné	1	11	0	1	9	6	0	2	30
Total colonnes	5	54	2	9	38	47	13	20	188
$X^2 = 35.61$	d.d.l. = 12		$s = 0.0004$						

Tableau 4. Situation professionnelle

Lieu	Retraités Longue maladie	Chômeur	Travail	Ne travaille pas, pas de métier	Total lignes
Elan	5	13	61	9	88
Privé	4	5	54	6	70
Conventionné	0	0	30	0	30
Total colonnes	9	18	145	15	188
$X^2 = 14.89$	d.d.l. = 8		$s = 0.061$		

Tableau 5. Education

Lieu	Ecole primaire seulement	4 années études secondaires	Fin école secondaire, début collège	Collège, université	Total lignes
Elan	5	23	25	35	88
Privé	0	4	23	43	70
Conventionné	1	12	11	6	30
Total colonnes	6	39	59	84	188
$X^2 = 27.69$ d.d.l. = 6 $s = 0.0001$					

Tableau 6. Mobilité sociale

Lieu	Mobilité descendante	Pas de mobilité	Mobilité ascendante	Total lignes
Elan	13	49	23	85
Privé	4	46	15	65
Conventionné	3	10	16	29
Total colonnes	20	105	54	179
$X^2 = 14.67$ d.d.l. = 4 $s = 0.0054$				

font soigner dans le secteur privé non remboursé, contre 34% dans les secteurs non-payants et remboursés. Cette différence n'est plus significative si on considère seulement la différence de lieu privé/public et le redevient si les trois lieux de pratique sont différenciés; ces variations sont dues au fait que 39% des patients de l'Institut ont une formation universitaire, tandis que seuls 20% des patients, vus par le psychiatre conventionné, ont atteint ce niveau d'études. La population soignée à l'Institut est donc plus instruite que celle soignée par le psychiatre conventionné, dont 40% des patients n'ont pas terminé leurs études secondaires (Tableau 5).

Mobilité sociale: La mobilité sociale évaluée par la comparaison de la profession actuelle du patient avec celle de ses parents, diffère suivant les lieux de soins: elle est la plus élevée pour les clients du psychiatre conventionné, dont 55.2% des patients sont en mobilité ascendante, et 34.5% sans mobilité. Pour cette clientèle, le milieu d'origine est donc très modeste puisque de nombreux patients sont eux-mêmes de simples employés.

Dans la clientèle des analystes la mobilité est presque inexistante: 71.2% sont issus du même milieu que leur milieu actuel: classe moyenne et supérieure. Lorsqu'il existe une mobilité sociale, elle est ascendante (22.7%).

Les patients ayant une mobilité sociale descendante sont presque tous pris en charge dans l'éta-

blissement gratuit (15.5%), ce qui coïncide probablement avec une image socialement dévalorisée d'eux-mêmes. Cependant, 27.4% des patients de l'Institut sont en mobilité sociale ascendante. Quand on regroupe les patients consultants dans le secteur privé, sans tenir compte du remboursement, et qu'on les compare à ceux vus à l'Institut, la différence de mobilité sociale disparaît (Tableau 6).

Les patients qui payent leur traitement ont presque tous passé leur enfance dans un milieu aisé, alors que ceux qui choisissent de ne pas prendre en charge financièrement leur cure, même s'ils ont une situation équivalente aux premiers au moment de la demande, sont issus de couches plus modestes, ce qui implique probablement un rapport différent à l'argent.

Situation familiale: La situation familiale en terme de mode de vie: seul, en concubinage, marié ou chez ses parents, est similaire pour tous les patients. Si on différencie les trois cadres de soins: institution, psychiatre conventionné, privé, une légère différence apparaît (significative à 6%). Cette différence isole la population vue par le psychiatre conventionné, mariée à 56.7%, par opposition aux autres populations où le pourcentage de séparés et divorcés est de 23% et 26.8%. Le concubinage est inexistant dans la clientèle du psychiatre conventionné, alors qu'il représente 15% des situations des patients vus à l'Institut ou dans le privé non remboursé. Le nombre d'enfants n'est pas différent quel que soit l'axe d'analyse (Tableau 7).

Mode de recrutement des différents lieux de soin: Le mode de recrutement différencie très bien les clientèles. Chaque lieu a son circuit propre. L'Institut reçoit des patients envoyés par des amis ou de la famille (42.5%); par des médecins correspondants: psychiatres ou généralistes, voire spécialistes dans d'autres domaines comme en gynécologie (27.6%); et des patients envoyés par d'autres institutions: médecine du travail, centres d'orientation professionnelle, etc... (26.4%).

Tableau 7. Situation familiale

Lieu	Chez ses parents	Seul	Séparé ou divorcé	Concubinage	Marié	Total lignes
Elan	9	22	20	13	24	88
Privé	4	15	19	11	21	70
Conventionné	4	6	2	1	17	30
Total colonnes	17	43	41	25	62	188
$\chi^2 = 14.90$ d.d.l. = 8 ns						

Tableau 8. Mode de référence

Lieu	Institution	Médecin	Amis, famille	Psychanalyse Psychologue	Total lignes
Elan	24	24	37	3	88
Privé	0	14	16	40	70
Conventionné	0	27	2	1	30
Total colonnes	24	65	55	44	188
$\chi^2 = 124.96$ d.d.l. = 6 s = 0.0000					

Tableau 9. Information sur la psychanalyse

Lieu	Pas au courant	Entendu parler	Radio, télé	Etudes, livres	Très informé	Total lignes
Elan	9	27	2	47	3	88
Privé	0	14	9	32	15	70
Conventionné	1	4	15	7	3	30
Total colonnes	10	45	26	86	21	188
$\chi^2 = 64.19$ d.d.l. = 8 s = 0.0000						

Les analystes reçoivent leurs patients d'autres analystes (56.3%); de leurs propres patients (22.5%); et quelques-uns de médecins (19.7%).

Ce dernier mode de recrutement est par contre celui du psychiatre conventionné qui reçoit 90% de sa clientèle de collègues médecins. Le psychiatre conventionné travaille donc comme un médecin spécialiste, avec des correspondants locaux généralistes qui lui adressent des patients. Ceci mis à part, dans le circuit privé, les patients proviennent plutôt d'un réseau professionnel, de médecins ou d'analystes, tandis que davantage de patients du réseau public sont adressés directement, sans intermédiaire, par des amis ou des organisations qu'ils ont contactés eux-mêmes (Tableau 8).

Informations quant à la psychanalyse: Les trois clientèles diffèrent quant à leur niveau d'information sur la psychanalyse. Seuls les analystes reçoivent des patients «très informés» (21.1%), c'est à dire ayant une information supérieure à celle obtenue par des lectures ou des études (ils ont eux-mêmes été, ou ont

quelqu'un de très proche, en analyse). L'Institut reçoit beaucoup de patients ayant une culture analytique acquise par des lectures ou des études (52.9%), ce qui correspond au nombre important de patients ayant fait des études supérieures.

Le psychiatre conventionné a une clientèle dont l'information provient des médias: télévision ou radio (50%), type d'information pratiquement inexistante dans les autres clientèles.

Seuls 10% de l'ensemble des patients ne savent pas ce qu'est la psychanalyse et ils sont presque tous vus à l'Institut (Tableau 9).

Le revenu: C'est une variable très liée au lieu de soins: les patients, dont les revenus sont les plus bas, sont pris en charge dans l'institution gratuite ou chez le psychiatre conventionné, dont les patients ont des revenus plus élevés, en moyenne, qu'à l'Institut. Les patients ayant les revenus les plus hauts, sont dans le privé non remboursés. Cependant, bien que cette tendance soit indéniable et très significative, la moitié des patients qui consultent dans le secteur privé pa-

Tableau 10. Revenu mensuel des patients

Lieu	< 3 000 F	3 000 à 4 000 F	4 000 à 6 000 F	6 000 à 8 000 F	> 8 000 F	Total lignes
Elan	18	33	24	8	4	87
Privé	6	17	19	14	14	70
Conventionné	5	8	11	4	1	29
Total colonnes	29	58	54	26	19	186
$X^2 = 20.90$	d.d.l. = 8		s = 0.0074			

Tableau 11. Diagnostic DSM III

Lieu	Psychotique	Déprimés	Névrosés symptomatiques	Personnalités névrotiques	Autres	Total lignes
Elan	8	28	17	33	2	88
Privé	12	7	16	35	0	70
Conventionné	2	2	7	18	1	30
Total colonnes	22	37	40	86	3	188
$X^2 = 20.59$	d.d.l. = 8		s = 0.0083			

yant ont des revenus relativement modestes, inférieurs à Fr. 6 000 mensuels; seuls 20% ont des revenus de plus de Fr. 8 000 mensuels.

Une analyse à trois séances par semaine correspond donc à une partie importante du revenu de ces patients. Inversement, on trouve dans les lieux de soins gratuits ou remboursés, des patients à revenu relativement élevé. Ceci confirme l'importance de facteurs autres que le revenu, dans le choix du lieu de traitement (Tableau 10).

Résultats cliniques

Diagnostic: Les diagnostics portés selon la classification D.S.M. III, sont différents dans les trois sous-échantillons. Cependant, la différence est inattendue. On prévoyait que les patients les plus graves seraient vus en général en Institution. Or, c'est chez les analystes non conventionnés que se retrouve le plus fort pourcentage de patients diagnostiqués psychotiques (16.9%), alors qu'il n'est que de 9.2% à l'Institut et de 6.7% chez le psychiatre conventionné.

Ceci implique plusieurs remarques: la clientèle des analystes est celle qui a la meilleure instruction et le niveau social le plus élevé. Il semble que ces facteurs aient une influence sur le type de traitements proposés en cas de psychose. Il n'est question ici que de psychothérapies. Les indications de psychothérapies se sont largement étendues au-delà de la névrose, du moins pour une certaine clientèle.

Par ailleurs, le pourcentage des psychotiques vus à l'Institut a pu être abaissé artificiellement parce que

nous avons exclu au départ les demandes dites «autres» que psychothérapiques, que les psychotiques ont le plus de chance de faire. Cependant, même si on réintroduit ces patients pour prendre en compte tous les patients vus à l'Institut, quelle que soit leur demande, le pourcentage de psychotiques est alors identique à celui vu dans le secteur privé. Il ne s'agit donc pas d'un artéfact dû à l'exclusion de certains patients de l'échantillon recevant des soins gratuits.

Ce résultat est d'ailleurs corroboré par des enquêtes récentes menées aux USA qui démontrent que de nombreux psychotiques sont suivis dans le secteur privé. Il semble cependant que les psychotiques suivis dans le secteur privé sont ceux qui ont pu faire des acquisitions intellectuelles supérieures à la moyenne de la population, et qu'ils sont de milieux plus protégés. Ceci leur permet d'avoir accès à la psychothérapie comme forme de traitement.

Les troubles affectifs sont des troubles dépressifs, et il s'agit de dépressions névrotiques et réactionnelles dans tous les cas. Ces dépressions sont plus fréquentes dans la clientèle de l'Institut où elles représentent 32.2% des cas (dont 11% ayant fait des tentatives de suicide). Cela semble être la pathologie qui amène les patients de classe moyenne ou basse à consulter.

La pathologie vue par les analystes est davantage celle des troubles de la personnalité ou des difficultés d'adaptation (49.3%). Cette pathologie est encore plus fréquente chez le psychiatre conventionné (60%). Les névroses structurées représentent environ le quart de chacune des clientèles (Tableau 11).

Tableau 12. Prise en charge antérieure

Lieu	Hospita- lisation	Psycho- thérapies analyse	Médica- ments	Aucune	Total lignes
Elan	20	19	23	26	88
Privé	5	2	21	42	70
Conventionné	5	4	4	17	30
Total colonnes	30	25	48	85	188
$X^2 = 27.58$ d.d.l. = 6 $s = 0.0001$					

Tableau 13. Prise en charge concomitante

Lieu	Médicale psychiatrique	Psycho- thérapie analyse	Aucune	Total lignes
Elan	15	4	69	88
Privé	7	1	62	70
Conventionné	18	1	11	30
Total colonnes	40	6	142	188
$X^2 = 34.93$ d.d.l. = 4 $s = 0.0000$				

Tableau 14. Objectifs des patients

Lieu	On leur a dit de venir ou parler	Symptômes	Changer	Total lignes
Elan	23	37	28	88
Privé	16	22	32	70
Conventionné	8	14	8	30
Total colonnes	47	73	68	188
$X^2 = 4.88$ d.d.l. = 4 NS (s 0.30)				
Gratuit ou remboursé	31	51	36	118
Payant	16	22	32	70
Total colonnes	47	73	68	188
$X^2 = 4.59$ d.d.l. = 2 NS (s 0.10)				
Elan	23	37	28	88
Privé	24	36	40	100
Total colonnes	47	73	68	188
$X^2 = 1.39$ d.d.l. = 2 NS (s 0.50)				

Antécédents

Prises en charge antérieures: La demande de psychothérapie n'est pas, en règle générale, la première prise en charge demandée par le patient: 55% des patients avaient déjà entrepris un traitement avant de faire la demande que nous étudions. C'est à l'Institut que se retrouve le pourcentage le plus élevé de patients ayant

déjà été pris en charge: 71%, tandis que dans le secteur privé ce pourcentage n'est que de 40%.

L'Institut est donc un lieu où les patients arrivent après avoir essayé autre chose. Plusieurs explications peuvent être envisagées. La gratuité peut favoriser la demande des patients passifs-dépendants (qui ont de toute façon plus tendance que les autres à demander quelque chose, Nash et Cavenar 1976). La gratuité peut favoriser une demande de psychothérapie de la part de patients qui ne sont pas vraiment motivés (Goodman 1960). Enfin, la clientèle de l'Institut peut tout simplement ne pas avoir été satisfaite ailleurs (21.6% avaient déjà entrepris une psychothérapie contre 2.9% dans la clientèle des analystes (Tableau 12).

Prises en charge concomitantes: Un certain nombre de patients continuent à être suivis dans un autre lieu alors qu'ils font une demande de psychothérapie. Ils peuvent, par exemple, avoir besoin de médicaments que le thérapeute ne peut pas prescrire lui-même. En fait, chez les patients vus à l'Institut et chez ceux vus chez les analystes privés, cette pratique est relativement rare: 79.3% et 87.3% respectivement n'ont aucune autre prise en charge que leur psychothérapie, ou leur analyse.

Par contre, 60% des patients vus par le psychiatre conventionné continuent à être vus par leur médecin généraliste durant leur thérapie: en effet, ce psychiatre travaille en collaboration étroite avec les généralistes qui lui adressent les patients auxquels il confie le soin de prescrire des médicaments si besoin est, tandis qu'il effectue les psychothérapies. Ceci permet au généraliste de garder le contact avec son patient (Tableau 13).

Les antécédents personnels et familiaux sont comparables dans les différentes clientèles.

La demande

Les objectifs: Nous avons décidé, lors de l'analyse, de regrouper les patients qui semblaient ne pas avoir d'objectifs par eux-mêmes, avec ceux dont les objectifs n'étaient pas plus précis que «parler», par opposition à ceux qui recherchaient un traitement psychothérapique: soit pour être débarrassés de leurs symptômes, soit pour changer. Pris dans chacun des trois contextes, les objectifs des patients sont semblablement répartis: 25% viennent sans objectifs vraiment thérapeutiques, 38.8% pour être soignés de leurs symptômes et 36.2% pour «changer». La population vue à l'Institut et celle vue par le psychiatre conventionné sont assez identiques.

Si l'on compare les patients en traitement payant, aux patients en traitement gratuit ou remboursé, une

différence bien que non significative (10%) apparaît dans le sens d'un pourcentage inférieur d'objectifs «changer» chez les patients non payants, compensé par un fort pourcentage d'objectifs «se débarrasser de ses symptômes». Il est intéressant de remarquer que, par contre, la comparaison public/privé annule ces différences, donc c'est le facteur «paiement» qui intervient et non le facteur «privé ou public».

Ceci pourrait s'expliquer par l'hypothèse que les traitements gratuits ou remboursés concordent avec des objectifs de type médicaux, tandis que les traitements payants concordent avec des objectifs plus analytiques (Tableau 14).

Degré d'insight: Il est étonnant de constater que l'insight, mesuré d'après la façon dont le patient conçoit l'origine de ses difficultés, est réparti de la même façon dans les trois clientèles: la moitié des patients invoque leur enfance, un quart leurs problèmes actuels, peu sont incapables de donner une raison, et 17% ont un abord considéré comme analytique, retrouvé avec une fréquence égale, tant à l'Institut que chez les analystes privés qui ont les populations ayant le niveau d'instruction le plus élevé (Tableau 15).

Les attentes: Si l'insight est relativement semblable suivant les trois sous-échantillons, il n'en est pas de même des attentes formulées par le patient, c'est-à-dire le traitement qu'il demande. Cependant, les demandes de psychothérapies sont identiques dans les trois groupes, soit 40% des attentes. Les variations sont dues aux autres attentes: «parler» est une attente fréquente à l'Institut et très fréquente chez le psychiatre conventionné, tandis qu'une analyse demandée d'emblée est très fréquente chez les analystes (49.3%), relativement fréquente à l'Institut (22%), et totalement absente chez le psychiatre conventionné.

A notre avis, ces différences des attentes, beaucoup plus accentuées que celles des objectifs ou de l'insight, reflètent un degré d'information différent, de la part de populations d'éducation dissemblable. Il semble que cette information n'ait qu'un effet relatif sur les objectifs profonds des patients et joue surtout au niveau de la formulation de la demande et du lieu où cette demande est faite (Tableau 16).

Les indications: Les indications sont très semblables aux attentes qui semblent donc un facteur décisif. Ce que le patient demande lui est en général offert, avec des modifications qui accentuent le pourcentage des psychothérapies aux dépens des autres traitements, les faisant passer à 54% des traitements, dans le secteur gratuit et remboursé, et à 46.5% dans le secteur privé payant, soit presque 10% de plus que les attentes. D'une façon générale, ces indications de

Tableau 15. Insight: origine des difficultés selon le patient

Lieu	Ne sait pas	Problèmes actuels	Problèmes de l'enfance	Abord analytique	Total lignes
Elan	4	21	48	15	88
Privé	8	16	31	15	70
Conventionné	2	10	16	2	30
Total colonnes	14	47	95	32	188
$X^2 = 7.07$ d.d.l. = 6			ns		

Tableau 16. Traitement demandé par les patients

Lieu	Parler ou autres	Psychothérapie	Analyse	Total lignes
Elan	31	33	19	83
Privé	8	28	34	70
Conventionné	18	12	0	30
Total colonnes	57	73	53	183
$X^2 = 36.82$		d.d.l. = 4	$s = 0.0000$	

Tableau 17. Traitement proposé

Lieu	Entretiens	Psychothérapie	Psychanalyse	Total lignes
Elan	23	48	17	88
Privé	8	32	30	70
Conventionné	13	16	1	30
Total colonnes	44	96	48	188
$X^2 = 25.64$		d.d.l. = 4	$s = 0.0000$	

psychothérapie concernent des patients qui s'attendaient plutôt à des entretiens, ainsi que certains de ceux qui demandaient une analyse mais dont la pathologie n'a pas été jugée comme une bonne indication d'analyse par les analystes. Cette dernière éventualité est relativement rare, surtout à l'Institut (Tableau 17).

Le devenir

Devenir à court terme: La décision prise lors de l'entretien préliminaire diffère selon les lieux de pratique, bien que la tendance générale soit de prendre en charge les patients là où ils font une demande (dans 66.5% des cas, en moyenne). C'est à l'Institut que les patients sont le plus orientés vers l'extérieur car, par définition, les demandes d'analyse sont dirigées vers le secteur privé.

Ce sont les analystes qui voient le plus de patients qui, dès la première séance, décident qu'ils ne revien-

Tableau 18. Devenir à court terme

Lieu	Pas de suite	Orienté	Pris en charge sur place	Total lignes
Elan	7	22	59	88
Privé	14	10	46	70
Conventionné	3	6	20	29
Total colonnes	24	38	125	187
$X^2 = 12.14$ d.d.l. = 6 $s = 0.059$				

dront plus, et l'institution gratuite qui en voit le moins. Rappelons qu'il est habituel que les patients aient des entretiens avec plusieurs analystes avant de choisir celui qui leur convient le mieux. Cependant, ce dernier groupe est bien différencié de celui des patients qui décident de ne pas revenir.

La différence entre les secteurs payant et non payant, dans le taux des patients qui décident d'emblée de ne pas revenir, peut être interprétée dans le sens que lui donne Goodman (1960): l'argent agissant comme un filtre séparant les patients peu motivés des autres (Tableau 18).

Devenir à long terme: Le devenir à long terme est très différent, suivant les lieux de pratique considérés. Le taux d'abandon immédiat (nombre de séances inférieur ou égal à trois) est de beaucoup le plus élevé à l'Institut et un plus grand nombre de patients restent en cure au-delà de six mois chez des analystes privés. Le plus grand nombre de patients effectuant une psychothérapie brève se trouve chez le psychiatre conventionné.

Les abandons secondaires (entre quatre séances et six mois, sans l'accord du thérapeute) sont relativement rares (8% de l'échantillon global). Même à l'Institut, où ils représentent quand même 11%, ils sont dûs, pour la plupart, au départ d'un thérapeute. Il faut cependant considérer la mobilité professionnelle des thérapeutes dans les institutions, comme faisant partie de ce système de soins. Donc ces abandons seraient dûs, sinon à la thérapie, du moins au contexte institutionnel dans lequel elle est effectuée.

En somme, le problème des abandons de traitement se situe en début de traitement: les patients commencent ou ne commencent pas; ensuite, ils ont tendance à rester. Cet arrêt immédiat a lieu dans des conditions différentes dans chacun des contextes étudiés. Dans le privé, où les patients voient directement leur thérapeute et où celui-ci a le loisir de faire sa propre évaluation, une décision peut être prise d'emblée. Ainsi, 20% des patients décident alors, en accord avec l'analyste qu'il n'y a pas lieu de poursuivre et ne prennent pas de nouveau rendez-vous.

A l'Institut, le système est quelque peu différent puisque les patients ne voient pas directement leur thérapeute; ils doivent en fait attendre leur deuxième rendez-vous ou une lettre pour savoir celui qui leur a été désigné. Ceci explique que les abandons immédiats aient rarement lieu dès le premier entretien (8%) mais beaucoup plus, lors du deuxième et troisième entretien (36.6%). Chez le psychiatre conventionné, 10% des patients décident d'emblée de ne pas revenir, de plus, 12% ne reviendront plus après les premières séances, et dans ce cas, cela ne peut être attribué au fait que l'évaluation a été effectuée par une autre personne que le thérapeute lui-même.

Il est probable que ces abandons précoces, sont le reflet d'une incongruence entre le traitement proposé et l'attente du patient, même s'il a fait une demande de psychothérapie au départ, ou du fait de l'ambivalence de la demande, d'une méconnaissance des bases de la psychothérapie, ou d'une fuite vers la guérison. Rappelons que Graziano (1973), ayant étudié les patients qui abandonnent leur traitement, décrit deux sous-groupes: les uns ont abandonné du fait d'une pathologie lourde, mais les autres semblent plus sains que ceux restés en traitement. Quoiqu'il en soit, ce sont les systèmes de soins gratuits et remboursés qui ont les taux d'abandon précoce les plus élevés.

Pour comparer ceux qui restent en traitement au-delà de six mois, on doit tenir compte de la fréquence des séances. Dans le public, seuls 11% des patients ont été vus plus d'une fois par semaine, alors que dans le privé, 93% sont vus plus d'une fois (deux ou trois fois, voire plus, par semaine). Chez le psychiatre conventionné, aucun patient n'est vu à ce rythme. Inversement, aucun patient n'est vu moins d'une fois par semaine chez les analystes, alors que respectivement 33.3% et 56.7% des patients sont vus moins d'une fois par semaine dans les systèmes public et conventionné. La durée de la prise en charge n'a donc pas la même signification dans les différents lieux de soins: à l'Institut, le mode de prise en charge habituel est hebdomadaire (50% des patients), dans le privé bi ou tri-hebdomadaire (93% des patients), ou «à la demande» (23.3%).

Enfin, au-delà d'un an, il ne reste à l'Institut que 10% des patients qui étaient encore en traitement après six mois, soit 3.4% de l'échantillon total de départ, tandis que chez les analystes, il en reste un pourcentage beaucoup plus élevé (Tableau 19 a et b).

Conclusions

Prise dans son ensemble, la population des patients demandant une psychothérapie correspond à celle décrite par les auteurs d'autres pays (USA, Canada).

Tableau 19a. Devenir à long terme

Lieu	Drop out immédiat	Drop out secondaire	Psychothérapie brève	Reste au delà de 6 mois	Total lignes
Elan	33	9	3	33	78
Privé	17	3	3	37	60
Conventionné	7	2	6	10	25
Total colonnes	57	14	12	80	163
$\chi^2 = 18.25$	d.d.l. = 6	s = 0.0056			

Tableau 19b. Devenir à long terme des patients ayant pris un second rendez-vous

Lieu	Drop out immédiat	Drop out secondaire	Psychothérapie brève	Reste au-delà de 6 mois	Total lignes
Elan	26	9	3	33	71
Privé	3	3	3	37	46
Conventionné	4	2	6	10	22
Total colonnes	33	14	12	80	139
$\chi^2 = 29.01$	d.d.l. = 6	s = 0.0001			

Elle est en majorité féminine, jeune et relativement instruite, 66% des patients ont un niveau qui équivaut à celui du collège. Cette population est bien informée: la moitié des patients ont lu des livres sur la psychanalyse. La pathologie présentée est plutôt dans la lignée névrotique, bien qu'il y ait 11% de psychotiques. Ces patients ont une activité professionnelle qui les situe dans la classe moyenne.

L'analyse comparative des trois clientèles permet d'ébaucher différents profils. La clientèle des psychanalystes privés est dans l'ensemble une clientèle urbaine, habitant Paris même, bien que certains patients viennent de province. Les patients qui consultent les analystes privés ont fait des études supérieures et sont issus de la classe moyenne à laquelle ils appartiennent eux-mêmes. Ils ont accès directement aux psychanalystes et demandent souvent une psychanalyse. Ce sont eux qui restent en traitement le plus longtemps.

La clientèle du psychiatre conventionné est très différente: elle habite en banlieue, représente une classe inférieure à la précédente et d'extraction beaucoup plus modeste. Son niveau d'instruction est le plus bas des trois clientèles. Ces patients travaillent dans des emplois relativement subalternes (employés de bureau), leur information sur la psychanalyse provient de la télévision et non de lectures. Ils ont été adressés au psychiatre par un médecin généraliste. Ils sont mariés et plus rarement séparés ou en concubinage que les patients des autres clientèles. Ils sont donc plus conformes aux normes traditionnelles. La moitié d'entre eux est en mobilité sociale ascendante et n'est pas née où elle habite actuellement.

On peut se demander si ces caractéristiques sont celles de la clientèle des psychiatres conventionnés ou celles des habitants de la banlieue parisienne. En fait, les études de l'évolution de la population parisienne (I.N.E.D. 1978) montrent que Paris a perdu 500.000 habitants entre 1962 et 1975, tandis que la banlieue gagnait 2 millions d'habitants pendant cette période. Ces mouvements de population ont affecté des classes sociales différentes. Les banlieues résidentielles mises à part, la population de Paris correspond aux classes les plus élevées, et celle de la banlieue, à la classe moyenne ou basse. Nous pouvons donc considérer la clientèle de la banlieue comme représentative d'une classe sociale. Ce sont ces patients à qui sont proposées des psychothérapies brèves.

La clientèle de l'Institut est très mélangée. On y retrouve les patients des milieux les plus défavorisés, ceux qui sont en mobilité sociale descendante, les chômeurs, les étudiants et des patients issus de classes moyennes très semblables aux patients vus dans le contexte remboursé. Ils arrivent à l'Institut par des moyens très divers: les médecins généralistes, leur travail, les amis. On pourrait dire que cette clientèle est composée de patients de classe moyenne basse, et de patients qui, bien qu'ayant un niveau d'instruction assez élevé, ne sont pas ou pas encore intégrés socialement. Les modes de prise en charge antérieure à la demande sont très différents, suivant le niveau d'étude (χ^2 2 éducation par prise en charge antérieure = 30.21, ddl = 6, s = 0.0000). Ce sont les patients les moins instruits qui ont le plus été hospitalisés, tandis que les patients les plus instruits ont reçu des médica-

ments. La discrimination décrite par Hollingstead et Redlich existe donc également en France.

Le canal par lequel le patient fait sa demande (soit le premier contact) reflète son niveau d'instruction (chi 2 mode de référence instruction = 26.5, ddl = 9, $s = 0.002$). Les moins cultivés ont contacté un médecin généraliste et les plus cultivés directement un analyste. Ces canaux sont bien entendu liés à la quantité d'information des patients sur la psychanalyse (chi 2 = 37.69, ddl = 12, $s = 0.0002$) et aux objectifs: les patients qui viennent par l'intermédiaire d'un médecin ont plus tendance aux objectifs «symptomatiques», alors que ceux qui viennent par des amis ont des approches plus «analytiques» ($X^2 = 15.63$, ddl = 6, $s = 0.01$). Les ressources utilisées, lors de la recherche d'aide, sont donc fonction du niveau d'instruction.

En règle générale, c'est l'axe gratuit ou remboursé, versus payant, qui différencie le mieux les variables étudiées: les populations qui utilisent des soins gratuits et remboursés se ressemblent, et se différencient de la population qui utilise les soins payants. L'axe d'analyse: public versus privé, fait plutôt disparaître les différences. C'est donc l'argent et non l'institution qui est le facteur majeur de variation.

A la fin de ce travail, il nous semble que nous pouvons, avec des réserves qui s'imposent quant à la représentativité de notre échantillon d'analystes (il n'a pas été tiré au sort dans la population générale des consultants de la région parisienne) affirmer que:

Le centre de soins gratuits étudié, étend les applications de la psychanalyse à une clientèle qui autrement n'en bénéficierait pas; cependant, les applications de la psychanalyse qui sont offertes dans un contexte gratuit ou remboursé sont moins intensives que celles offertes dans le cadre payant².

² Les patients qui consultent dans le centre gratuit et qui veulent effectuer une psychanalyse sont dirigés vers des analystes privés (conventionnés ou non).

Ceci laisse persister un certain degré d'inégalité dans ce qui est à la disposition de patients de classes sociales différentes.

La constatation d'un plus grand nombre d'abandons précoces dans les contextes gratuit ou remboursé confirme l'existence de facteurs autres que financiers dans la demande, et laisse supposer que la gratuité des soins ne joue pas seulement dans le sens d'une facilitation d'accès à psychanalyse ou psychothérapie.

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A. Buras-Eisenberg
Institut de la Rochefoucauld
23 rue de la Rochefoucauld
F-75009 Paris
France

Postnatal depression: A comparison of African and Scottish women

John L. Cox¹

Department of Psychiatry, University of Edinburgh, Royal Edinburgh Hospital, Edinburgh, Scotland, UK

Summary. A total of 183 Ugandan women were interviewed at their first visit to a rural antenatal clinic and again 6-15 weeks after childbirth. The Luganda modification of Goldberg's Standardised Psychiatric Interview was administered on each occasion. Eighteen women had a depressive illness following childbirth, which in all but four had not been present during pregnancy. No association was found between postnatal depression and a hospital delivery, having a first baby or being unmarried. Anxiety neuroses were found in six women, and two had animal phobias. Schizophrenia and organic psychoses did not occur. The depressed Africans were unlikely to consult doctors because of their symptoms. When compared with Scottish women with postnatal depression, the depressed Africans were less likely to report guilt or self-blame.

Introduction

Since the risk of puerperal depression is believed to have been enhanced by recent changes in women's roles in Western society and by the increasing likelihood of delivery in hospital, it is sometimes thought that an African woman is relatively unlikely to become depressed in the puerperium. However the small amount of African literature on puerperal psychoses indicates that depressive illness can certainly occur at this time. Ebie (1972) described a series of 60 women with a puerperal psychosis and found 10 to have an affective disorder. Similary Swift (1972) found 2 of 40 women with a puerperal psychosis to be depressed although half of this sample were schizophrenic.

¹ Formerly Department of Psychiatry, Makerere University, Kampala, Uganda, Africa

The purpose of this present paper is to describe the frequency and symptomatology of puerperal depression in Africans and, by comparison with a similar prospective study of Scottish women, to determine the extent to which sociocultural factors may modify the symptoms of this disorder.

The study took place at Kasangati Health Centre near Kampala, which was adequately staffed and able to provide comprehensive community services. The mothers mainly belonged to the Ganda tribe. Most families could grow sufficient food because the ground was fertile and rainfall was usually plentiful. The main tasks of Ganda women were to cook, grow food and to look after their own children and those of others. One-third were co-wives and the extended family usually lived in the same village. One-third of the women were less than 20 years old and their mean age was 24 years.

The 25 villages which formed a defined research area consisted of scattered houses, usually surrounded by banana plantations. Dust tracks connected these villages and were usually passable by car, unless there had been heavy rain. Since there were no postal or telephone services, tracing some of the subjects was difficult. However, a mother was only "lost to follow-up" if three attempts to contact her had failed and neighbours or the village chief had been unable to tell us whether the mother had moved or if she had recently delivered.

The interviews started in June 1972 and were completed in May 1974. At that time Uganda was still peaceful and village life had not yet been disrupted by political changes.

Method

Of the 263 women interviewed at the booking-in antenatal visit at the centre, 183 delivered a live baby and formed the sample described in this paper. These

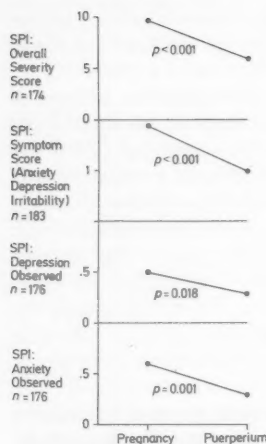


Fig. 1. Change in mean score between pregnancy and the puerperium for overall SPI score, anxiety, depression and irritability combined symptom score and individual depression anxiety ratings

183 women were re-interviewed, usually at home, about 3 months after childbirth. The Luganda modification of the Standardised Psychiatric Interview (SPI; Goldberg et al. 1970) was administered by J.C. and a trained Luganda-speaking research assistant. Orley and Wing (1979) report the SPI to have a high correlation with the Present State Examination (Wing et al. 1974) and it was found in general to be satisfactory for the limited descriptive purposes of this present study.

The SPI items used in the postnatal interview were similar to those of the antenatal interview, although in the puerperium each symptom was rated for two time periods: the previous 7 days and the time since delivery. The interviewers were always blind to the antenatal psychiatric ratings.

The inter-rater reliability between the author and the research assistant, who spoke both English and Luganda was satisfactory. Correlations of $r = 0.8$ were obtained for anxiety and depression scores, while the overall severity score (the sum of the symptom ratings and twice the mental state rating) had a higher correlation of $r = 0.9$. Any difficult ratings were discussed with the research assistant, and a psychiatric diagnosis agreed using the eighth edition of the *International Classification of Disease* (ICD). A single diagnosis of depressive illness was made, which included the ICD category of depressive neurosis and depressive psychosis. In general, the patients with a depressive illness would also have fulfilled Pitt's (1968) criteria for postnatal depression, which included distress to the mother and a duration

of at least 2 weeks. Social impairment was rated on a 4-point scale ranging from nil to severe, the latter rating being made if heavy digging or water-carrying had not been possible for at least 6 of the preceding 7 days.

In the prospective Scottish study, which also used the SPI, a representative sample of 89 women were interviewed on four occasions; at their booking-in antenatal clinic, during the third trimester, a week after delivery and 4 months later. A depressive illness was found in 13% of the total sample in the puerperium, compared with 4% during pregnancy; a further 16% of subjects reported persistent depressive symptoms following delivery. Full details of this study, are presented elsewhere (Cox et al. 1982).

Results

Comparison between the sociocultural characteristics of the 80 African women lost to follow-up and the remaining antenatal sample of 183 showed the former to be more likely to be living alone ($P < 0.05$), to have been married more recently ($P < 0.05$) and to have attended the antenatal clinic at more than 35 weeks gestation ($P < 0.01$). These women were also more likely to have experienced psychiatric symptoms during pregnancy and may therefore have been slightly more at risk of a puerperal psychiatric disorder than those mothers who were successfully re-interviewed.

Psychiatric diagnoses

Eighteen African women (10%) were found to have a depressive illness in the puerperium, usually commencing within 2 weeks of delivery. Of these 18 mothers, 6 were severely impaired by this disorder. No association was found between postnatal depression and women having a first child or being unmarried. Furthermore, mothers who had delivered their baby in a hospital were not more likely to be depressed than those who had home deliveries. In the interviewed group the mean overall severity score during pregnancy was 10.1 (SD = 11). In the puerperium it was 6.0 (SD = 9.4), a reduction in mean score that was significant at the 0.1% level. The total anxiety, depression and irritability symptom score was reduced in the puerperium; observed depression and anxiety also showed a significant reduction (Fig. 1).

Of the 18 depressed women only 4 had been depressed during pregnancy, while only 4 of 18 women with an antenatal depressive illness subsequently developed postnatal depression. In the majority, therefore, postnatal depression was not a continuation of a depressive illness which had begun before delivery. Guilt and self-blame were very rare and described by

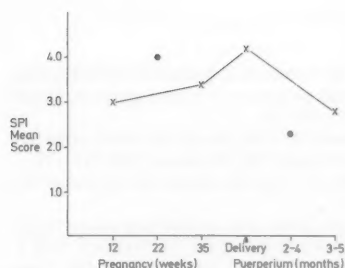


Fig. 2. SPI mean score (anxiety, depression, irritability) for African (●) $n = 178$ and Scottish women (X) $n = 89$

only two of the total sample interviewed. One mother said others were talking about her and also wondered what she had done to deserve this. The other mother believed that she was bad because she had an epileptic child.

Schizophrenia or organic psychoses were not described in any of the subjects; two had animal phobias – one fearing chameleons and the other caterpillars. Six subjects had an anxiety neurosis.

Comparison with Scottish women

The mean SPI scores for the Africans were then compared with the results of the Scottish study, the SPI score shown in Fig. 2 being the sum of the anxiety, depression and irritability symptom ratings plus twice the observed depression and anxiety scores. In general the Africans were observed to be more anxious and depressed than the Scots in pregnancy and more likely to report psychogenic somatic symptoms. The frequency of postnatal depression was 10% in the African and 13% in the Scottish sample. There were no differences in most SPI ratings between the Africans and Scots in the puerperium, although only two of the total African sample reported guilt and self-blame in the puerperium compared with at least nine of the Scots.

Discussion

These results need to be interpreted with caution because of the methodological limitations when women from a different culture to that of the researcher are being interviewed. However it is clear that postnatal depression is a common disorder in these rural African women and that a traditional way of life and having a home delivery does not reduce the likelihood of this illness. The depressed women were markedly dis-

tressed by their symptoms and were also socially impaired; some could not even carry out essential household tasks.

In the majority of women, depression began in the first weeks after childbirth and was not a continuation of a depressive illness that had begun in pregnancy. The frequency of postnatal depression in this study, moreover, is probably an under-estimate because women who could not be traced were probably more at risk of a postpartum psychiatric disorder and the medical services were far superior to those available elsewhere.

Although the comparison with the Scottish sample can only be made cautiously, because of the considerable sociocultural differences between the samples, the results do suggest that pregnancy, especially for an African mother, is particularly associated with an anxiety that generally exceeded that observed in the Scottish women. The Africans were more worried at this time about the physical risks of childbirth and often remembered their previous difficult deliveries. Some were even reminded of earlier stillbirths. Thus, although childbearing for an African conferred high status, it was also a time of much apprehension and was certainly not characterised by months of rural contentment. Successful delivery was therefore often associated with a reduction in anxiety; although for some women there was an increased likelihood of becoming depressed at this time. These depressive illnesses, which usually started soon after delivery, were often severe and ten mothers had marked diurnal variation of mood and early morning wakening.

That the Africans were in general less likely to report guilt or self-blame than the Scots is of interest. The Scots were more likely to be concerned with failure to live up to their expectations of the good mother, derived from their own mother's values or from their observations of friends or neighbours. The Scots were also more likely to question whether or not they were behaving correctly and were particularly concerned if they did not show sufficient affection towards their baby. The Africans by contrast only rarely described such feelings.

Despite these differences of symptoms, the frequency of postnatal depression was surprisingly similar in the two studies. This finding might even suggest that sociocultural factors were less important than biological variables in the aetiology of this disorder, especially as factors such as having a first child or being unmarried, which might increase stress, were not related to an increased likelihood of becoming depressed in either the African or the Scottish samples. Likewise, having a hospital delivery, which could be particularly worrying for an African mother because traditional birth rituals may not be observed, was not

found to increase the likelihood of postnatal depression.

The depressed Africans were unlikely to consult a doctor for their symptoms and their relatives may not have regarded them as ill at all. In this respect they were somewhat similar to the Scottish women, who also only rarely consulted a doctor. Traditional healers were probably far more likely to be consulted than doctors by the Ugandans – especially if the mother was thought to have a traditional puerperal mental illness (Cox 1979).

Little is known about the possible adverse repercussions of postnatal depression on the family and the nutrition of the baby. However, the greater availability of caretaker mothers in Ugandan society may not always compensate for the failure of a severely depressed mother to feed her infant. The findings of this study therefore suggest that maternal and child-health personnel require adequate training in both the recognition and treatment of this common postpartum psychiatric disorder.

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John L. Cox
Department of Psychiatry
Royal Edinburgh Hospital
Morningside Park
Edinburgh, EH 10 5 HF
Scotland, UK

Die Bedeutung der Informations- und Kooperationsverweigerung für die Interpretationsreichweite einer mehrstufigen kinderpsychiatrisch-epidemiologischen Untersuchung*

W. H. Allehoff, G. Esser, M. H. Schmidt und K. Henricke

Kinder- und Jugendpsychiatrische Klinik, Zentralinstitut für Seelische Gesundheit, Mannheim, FRG

Summary. Problems of non-response and refusal to co-operate acquire special significance in multi-stage epidemiological surveys, since the proportion of the survey sample which is affected tends to increase at each successive stage of the enquiry and may be so high as to throw serious doubt on the representative nature of the research findings. In an investigation of psychiatric disorder among 8-year-old children in Mannheim, the total proportion of refusal at any of the four stages of the enquiry amounted to 38.5%. Parents who co-operated at all stages were compared, both with those who refused further co-operation at a later stage and with those who refused from the outset. The latter group formed the subject of a special sub-study of refusers. The finding reported by Cox et al. (1977), that children of refusers score higher on average than other children on teachers' ratings for behaviour disturbance could not be confirmed. Children whose parents refused had on average a lower IQ and more scholastic difficulties than those whose parents were co-operative, but did not appear to be more deviant in behaviour. There is thus no firm evidence from this study of an excess of psychiatric disorder among the children of refusers. Reasons postulated for this discrepant finding include the high over-all refusal rate in the present study, a possible tendency to dissimulation among the refusal sub-group and also possible variation among different samples in the motives for participation or refusal. The association reported by Cox et al., whose refusal rate was much lower (8.4%), probably relates to a small hard-core group of refusers. The prevalence of psychiatric disturbance found in the present study is,

therefore, unlikely to have been more seriously underestimated than in other surveys with lower refusal rates.

Zusammenfassung. Für mehrstufig angelegte epidemiologische Untersuchungen ist das Problem der Verweigerer besonders drängend, weil sich die Quoten über die Stufen aufsummieren und bei hohen Verweigererquoten Zweifel an der Repräsentativität der Ergebnisse auftreten. Bei einer entsprechenden kinderpsychiatrischen Untersuchung an achtjährigen Kindern in Mannheim trat eine Quote von 38,5% über vier Untersuchungsstufen auf. Es wurden die Eltern, die an der Untersuchung teilnahmen mit denen, die im Verlaufe der Untersuchung verweigerten und mit denen, die die Gesamtuntersuchung von vornherein ablehnten, verglichen. Letztere waren Gegenstand einer speziellen Verweigereruntersuchung. Die von Cox et al. (1977) bei einer Verweigererquote von 8,4% berichteten Ergebnisse, daß Kinder von Verweigerern speziell im Urteil der Lehrer verhaltensauffälliger sind, konnten wir *nicht* bestätigen. Die Kinder der verweigernden Eltern hatten einen geringeren IQ, mehr Schulschwierigkeiten, waren aber nicht auffälliger in bezug auf psychiatrische Symptome als die Teilnehmer. Die Ergebnisse sind also im Hinblick auf eine allgemeine Auffälligkeit der Kinder uneinheitlich. Erklärungen hierfür sind: unsere hohe Verweigererquote, mögliche Dissimulationstendenzen und unter Umständen eine unterschiedliche Teilnahmemotivation. Die von Cox et al. berichteten Ergebnisse betreffen vermutlich den harten Kern der Verweigerer. Die Prävalenz kinderpsychiatrischer Auffälligkeit wird deshalb in unserer Untersuchung nicht stärker unterschätzt als in Studien mit geringen Quoten.

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Einleitung

Für sozialwissenschaftliche Umfragen und für kinderpsychiatrisch-epidemiologische Untersuchungen ist das Phänomen der Verweigerung der Mitarbeit eines der größten ungelösten Probleme. Es wird zwar vermutet, daß hohe Raten aktiver wie passiver Verweigerer¹ zu „trivialen“ Ergebnissen führen, aber eine allseits anerkannte „Theorie der Verweigerung“ gibt es nicht, lediglich eine Reihe Erklärungsversuche, die aber oft ad-hoc-Charakter haben, auch deshalb, weil über Verweigerer ja wenig Informationen vorliegen (Erbslöh 1973; Esser 1973; Reschka 1973; Schöne 1973). Bei Studien, die Kinder als Informationsquellen benutzen, entscheiden darüber hinaus nicht diese selbst, sondern die Erziehungsberechtigten über die Mitarbeit oder Verweigerung. Je nach Höhe der Verweigerungsquote (Sheatsley 1948 zitiert nach Esser 1973 gibt 7–15% als durchschnittliche Werte an, vgl. auch Esser 1980), nimmt man diese entweder als naturgegeben hin und versucht sie in ein theoretisches Konzept einzuordnen, oder man schließt eine spezielle „Verweigereruntersuchung“ an, was natürlich sowohl von finanziellen als auch inhaltlichen Aufwand/Nutzen-Überlegungen abhängig ist. Um überhaupt Aussagen über Verweigerer machen zu können, stellt man sich das Merkmal Verweigerung nicht als von der Teilnahme getrennt, sondern als Kontinuum vor, auf dem verschiedene Schweregrade von der Zustimmung bis zur ganz konsequenten Verweigerung unterschieden werden können. Es wäre somit ein Schluß von Kooperationsunwilligen mit leichter Ausprägung auf solche mit hoher Ausprägung möglich. Ohne Berücksichtigung der absoluten Höhe der Verweigererquote sind solche Schlüsse allerdings problematisch.

Problemstellung

Hypothetische Erklärungsversuche des Phänomens Verweigerung (Abb. 1)

Die „Desintegrationsthese“ nimmt an, daß Personen oder ganze soziale Gruppen entsprechend ihrer Partizipation oder Isolation am bzw. vom öffentlichen Leben an Forschungsprojekten der empirischen Sozialforschung teilnehmen oder nicht. Bestärkt wird diese These durch die Beobachtung, daß Verweigerung häufiger bei älteren Personen, Personen mit nie-

drigem sozialen Status und geringer Schulbildung sowie bei Frauen vorkommt (Esser 1973).

Die These von den „Kommunikationsbarrieren“ behauptet, daß bestimmte Subkulturen einer Gesellschaft deshalb verweigern, weil sie zu bestimmten Themen schlechtweg keine Meinung entwickelt haben. Esser 1973 geht im wesentlichen von zwei Einstellungsdimensionen bei den Befragten aus:

Anerkennung vs. Nichtanerkennung der Ziele der empirischen Sozialforschung.

Positive vs. negative Einstellung zu sozialem Wandel.

Personen, die die Relevanz der Sozialforschung bezweifeln und sozialen Wandel eher ablehnen, dürften demnach eher verweigern.

In der Praxis der Datenerhebung liegt das Hauptaugenmerk jedoch auf dem Interviewer (Erbslöh 1973; Reschka 1973). Von ihm wird erwartet, daß er sich in Bezug auf die „Interviewervariablen“ (siehe Abb. 1) auf den zu Befragenden einstellt und diesen zu gültigen Aussagen bewegt, ohne ihn zu aktiver oder passiver Verweigerung (sozial erwünschte oder triviale Antworten) zu provozieren. Zwar ist die Verweigererquote eine Funktion der Hartnäckigkeit des Interviewers, jedoch werden „bedrängte“ Befragte Aussagen machen, die nicht besonders valide sind.

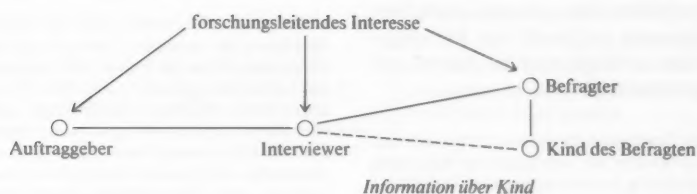
In der empirischen Sozialforschung ist es in allen Bereichen so, daß diejenigen an der Spitze der Institutshierarchie, die die Forschungsfragen und Designs festlegen, ein tiefergehendes Interesse am Ergebnis einer Studie haben als die Interviewer, die im Normalfall keine Möglichkeit haben, die Erstellung eines Fragebogens zu beeinflussen. Sie führen das Interview durch, auch wenn sie Sinn und Zweck nicht einsehen. Andererseits steht und fällt eine Untersuchung mit der Fähigkeit des Interviewers den Befragten zur Mitarbeit überhaupt zu motivieren und ihn zu gültigen Antworten zu bewegen.

Vom Interviewer verlangt man also die Unterordnung unter Frageleitfaden und Untersuchungsdesign und gleichzeitig die souveräne Kontrolle der Befragten. Die Rolle des Interviewers ist daher ziemlich „entfremdet“. Nach Wissen der Autoren gibt es darüber noch keine Untersuchung. Wir haben für die vorliegende Untersuchung versucht, das Problem zu lösen durch größtmögliche Integration aller Interviewer in das Forschungsvorhaben (vgl. Allehoff 1977).

Erfahrungen aus der Analyse von Ausfällen bei postalischen Befragungen (Schöne 1973) führten zu der Vermutung, daß der Befragte bei der Entscheidung zur Kooperation nicht nur die Interaktion mit dem Interviewer berücksichtigt, sondern auch die Fragestellung in das soziale Umfeld eingebettet sieht. Damit kann die Kooperation nicht nur als Folge der Interaktion mit dem Interviewer, sondern als Stellungnahme des Befragten zu diesem sozialen Umfeld

¹ Aktive Verweigerer lehnen in unserer Definition eine Informationsabgabe grundsätzlich ab, passive Verweigerer geben zwar Antworten, die aber durch Antworttendenzen verfälscht und deshalb belanglos sind.

Soziales Umfeld



Variablen des sozialen Umfelds	Kommunikationsvariablen	Interviewervariablen	Variablen des Befragten
Ansprechphase (persönlich/postalisch) Einleitungsphase (persönlich/telefonisch) Soziale Distanz (Schicht, Sprache) Auftraggebereffekte Imagefaktoren des testenden Instituts – universitär – öffentlich – privat Einflüsse des Orts des Interviews – im Haushalt des Befragten – im Institut Tabuisierte Bereiche – Sexualität – Delinquenz	atmosphärische Variablen Interviewer-know-how „Sättigungsgrenze“ ^a Entfremdung des Interviewers Akzeptanz des forschungsleitenden Interesses	Auftreten Kleidung Geschlecht Alter Soziale Stellung Persönlichkeit (intro-extravertiert) Geburtsland Sprache Religion/Ideologie Interviewertechnik	Auftreten Kleidung Geschlecht Alter Soziale Stellung Persönlichkeit (intro-extravertiert) Geburtsland Sprache Religion/Ideologie un-/auffälliges Kind Angst vor Übervorteilung „Hausiererereffekt“ Informiertheit über Datenschutz

^a Anzahl gleichartiger Interviews, die einem Interviewer abverlangt werden können, ohne einen Qualitätsverlust wegen „Interviewermüdigkeit“ zu erreichen

Abb. 1. Variablen als Gründe für aktive und passive Informations- und Kooperationsverweigerung

im allgemeinen und zum testenden Institut im besonderen angesehen werden. Je nach Ausmaß der subjektiv empfundenen sozialen Distanz des Befragten zum forschungsleitenden Interesse und zum testenden Institut, wird die Kooperationsbereitschaft groß oder gering sein.

Bei kinderpsychiatrisch epidemiologischen Untersuchungen ist der eigentliche Informant das Kind, die relevanten Informationen werden aber über die Eltern vermittelt, die auch über die Teilnahme entscheiden. Zusätzlich zu den oben geschilderten Variablen kann mit Cox et al. (1977) vermutet werden, daß Eltern mit verhaltensauffälligen Kindern eher unkooperativ sind, als Eltern mit unauffälligen Kindern. In Abbildung 1 haben wir die Variablen in einem theoretischen Konzept zusammengestellt, von denen wir einen Einfluß auf Verweigerungsmöglichkeiten

annahmen und die wir deshalb kontrolliert, konstant gehalten oder minimiert haben.

Arbeitshypothesen zur Verweigerung in einer mehrstufigen kinderpsychiatrisch epidemiologischen Untersuchung

Unsystematische (wegen Nichterreichbarkeit, Umzug, Tod etc.) und systematische Ausfälle (aktive Verweigerung) werden in der empirischen Sozialforschung als notwendiges Übel angesehen (Esser 1973). Bei den systematischen Verzerrungen wird mit einem Mittelschichtbias gerechnet, der die Verallgemeinerung der Ergebnisse auf alle Schichten einer Gesellschaft in Frage stellt. Für den Bereich der psychiatrischen Epidemiologie liegt unseres Wissens keine Arbeit vor, die dieses Problem genau untersucht, ein

schichtspezifisches Informations- und Kooperationsverhalten kann jedoch erwartet werden.

Cox et al. (1977) schildern die systematischen Verzerrungen der Schätzwerte aufgrund von Verweigerungen, die bei der Isle-of-Wight und der Inner-London-Study zutage getreten sind.

13jährige, die wegen eines Lesetests in der Schule fehlten oder unabhängig davon unter Umständen als Verweigerer zu betrachten waren, hatten doppelt so häufig Lesestörungen und Verhaltensauffälligkeiten als die teilnehmenden. Diese „Verweigerung“ erscheint hier als Ausdruck einer Verhaltensauffälligkeit.

Cox et al. verglichen auch die nonverbale Intelligenz, die Leseleistung, die Schichtzugehörigkeit und das Lehrerurteil von zehnjährigen Kindern, deren Eltern sich weigerten (8,4%), an kinderpsychiatrischen Interviews teilzunehmen, also unseren Verweigerern am ähnlichsten waren. Für die Merkmale Intelligenz, Leseleistung und Schicht traten keine signifikanten Unterschiede zu der teilnehmenden Gruppe auf, jedoch wurde ein höherer Teil der Verweigerer von den Lehrern als verhaltensauffällig eingestuft.

Aus den vorliegenden Ergebnissen leiten wir folgenden Arbeitshypothesen ab:

A. Für Leistungsvariablen der Kinder erwarten wir wie Cox et al. keine gravierenden Unterschiede zwischen den Teilnehmern und den Verweigerern.

B. In der Gruppe der Verweigerer erwarten wir eine höhere Anzahl an verhaltensauffälligen Kindern anzutreffen als in der Gruppe der Teilnehmer.

C. Als Ausdruck der sozialen Distanz erwarten wir einen höheren Unterschichtanteil in der Gruppe der Verweigerer als in der Gruppe der Teilnehmer.

Wenn diese Arbeitshypothesen zutreffen, wäre daraus unter Umständen zu folgern, daß der Prozentanteil an auffälligen Kindern bei den verweigernden Eltern unterschätzt wird. Bedeutungsvoll sind dann die absolute Höhe der Verweigerungsquote, und die Frage, ob zwischen dieser und der Quote an verhaltensauffälligen Kindern ein linearer Zusammenhang besteht.

Vorgehen

Die Stichprobe der hier referierten Untersuchung besteht aus 361 achtjährigen Mannheimer Kindern, die die Grundschule besuchen. Die Kinder wurden mit Hilfe eines Zufallsverfahrens bestimmt. 198 von diesen 361 bilden die eigentliche Zufallsgruppe (Z), die übrigen 163 dienen als Zufallsersatzgruppe (ZE), d. h. diese Kinder rücken in vorgeschriebener Reihenfolge in die Zufallsgruppe auf und ersetzen etwaige Ausfälle der Z-Gruppe.

Der Untersuchungsablauf gliedert sich in vier kritische Zeitpunkte oder Stufen, auf denen theoretisch die weitere Mitarbeit verweigert werden kann, was im

Hinblick auf unvollständige Datensätze natürlich einen kumulativen Effekt hat (Abb. 2).

a. Auf unser erstes postalisches Anschreiben konnte eine völlige Ablehnung der gesamten Untersuchung erfolgen. 29,4% der Zufallsgruppe haben die Eltern- und Lehrerratings sowie alle weiteren Untersuchungsschritte abgelehnt. Bei denjenigen, die auf die ungewohnte schriftliche Aufforderung zunächst nicht reagierten, sie offenbar einfach verlegten oder vergaßen, oder die zunächst wirklich kein Interesse hatten, führte offensichtlich die persönliche Ansprache durch unsere Sozialarbeiterinnen und die mündliche Aufklärung über Ziel und Inhalt der Untersuchung zur Teilnahme.

b. Die Verweigerung der Schultestung fand nur durch ein Kind statt, obwohl die Eltern einverstanden waren. Es befindet sich nicht in der Zufallsstichprobe und ist deshalb hier irrelevant.

c. Die Untersuchung ihres Kindes am Zentralinstitut für Seelische Gesundheit in Mannheim (ZI) lehnten 9% der Eltern trotz vorher gegebener schriftlicher Zusage bei Einladung ab. Die unsystematischen stichprobenneutralen Ausfälle auf dieser Stufe (wegen Umzug, Todesfall, ambulanter Behandlung, Unauffindbarkeit, Nichterreichbarkeit) betragen 5,8%.

d. Das Familieninterview im Haushalt der Befragten haben 4,6% der Eltern der bis zu diesem Schritt Untersuchten abgelehnt.

Insgesamt mußten wir bei unserer Untersuchung eine Ausfallquote von 42,6% bezogen auf die Zufallsgruppe hinnehmen, die Quote der reinen Verweigerer beträgt über alle vier Stufen 38,5%. Angesichts dieser Tatsache haben wir nach Abschluß der Datenerhebung 61 der 106 Gesamtuntersuchungsverweigerer (Stufe 1) und 15 der 23 ZI-Verweigerer (Stufe 3) als Stichprobe für eine spezielle Verweigerernachbefragung angesehen und interviewt (mittels Kurzform vorhandener Befragungsinstrumente, dabei handelte es sich vor allem um sozialstatistische Angaben und um das Kind betreffende psychiatrische Symptome). Von den 76 aufgesuchten Personen haben 55 (73,3%) die Fragen beantwortet, 7 (9,2%) waren trotz mehrfachen Aufsuchens nicht erreichbar und müssen daher als unsystematische Ausfälle betrachtet werden.

Ergebnisse

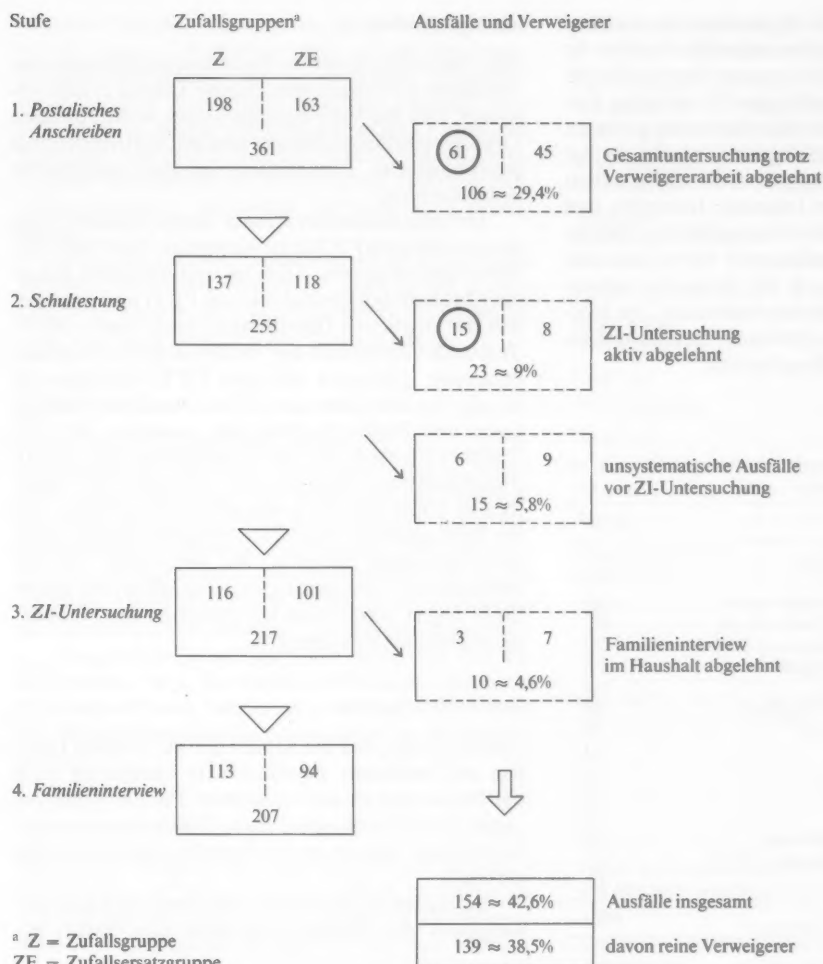
Wir versuchen im folgenden anhand der obigen Fragestellungen, Aussagen zu machen über:

die Leistungsvariablen der Kinder, dafür können die ZI-Verweigerer ($n = 23$) herangezogen werden;
die psychiatrische Auffälligkeit der Kinder, dafür sollen die Verweigerer aus der Verweigererstudie genommen werden ($n = 55$);
die Schichtzugehörigkeit, Aussagen darüber sollen ebenfalls an den Verweigerern der Verweigererstudie gewonnen werden.

Die Familieninterviewverweigerer ($n = 10$) wurden wegen der geringen Anzahl unberücksichtigt gelassen.

Bevor auf die Verweigerer eingegangen wird, erscheint es wichtig, die motivierenden Aspekte der Teilnehmer zu erläutern.

Zunächst hatten viele Eltern die Erwartung, Informationen über allgemeine Erziehungsfragen oder



Es wurden so lange Ausfälle bei der Zufallsgruppe durch Auffüllen aus der Zufallsersatzgruppe ergänzt, bis ungefähr 200 vollständige Datensätze der beiden Zufallsgruppen vorlagen. Die Verweigererstudie befaßt sich mit den 61 + 15 = 76 Verweigerern der Zufallsgruppe Z

Abb. 2. Verweigerungsraten für die Zufallsstichproben auf den einzelnen Stufen der Untersuchung

über den konkreten Entwicklungsstand ihres Kindes zu erhalten. Häufig wurden auch Fragen nach der weiteren Beschulung des Kindes gestellt, vor allem erhoffte man sich Aufklärung über die Intelligenz und die schulische Leistungsfähigkeit. Zweifellos war für viele Eltern ein wesentlicher Grund die Erwartung auf eine Beratung oder Hilfe, unabhängig davon, ob sie mit ihrem Kind Schwierigkeiten hatten oder nicht. (Ähnliche Motive können auch bei den Teilnehmern vermutet werden, die zunächst die Teilnahme verweigerten, schließlich jedoch der Untersuchung zustimmten).

Die Verweigerung auf der ersten Stufe kann als Resultat der sozialen Distanz zur Untersuchungsinstitution gewertet werden.

Ungefähr ein Drittel der überhaupt erfaßten Gesamtverweigerer haben die Kooperation ohne Angabe von Gründen abgelehnt, so daß es nicht möglich ist, irgendwelche Angaben über die Probanden zu machen. Tabelle 1 zeigt die Häufigkeit von Verweigerungsgründen, von denen mehrere angegeben werden konnten. Fast die Hälfte aller Eltern lehnten die Untersuchung mit dem Hinweis auf irgendwelche psychischen oder physischen Hindernisse ab oder sie

sahen keinen Grund für die Teilnahme, da das Kind normal sei und keine Schwierigkeiten bereite. In knapp einem Drittel der Fälle wurden Begründungen vorgebracht, die wenig Verständnis für derartige Untersuchungen anzeigen, einschließlich eines geringen Teils, dem von dritter Seite abgeraten wurde. In fast 16% wurden Zeitgründe angegeben, die Hälfte davon äußerte sogar prinzipielles Interesse. Immerhin fast 7% verweigerten aus Angst vor mangelhaftem Datenschutz. Eine versuchte Typologie der Verweigerer mit der Fragestellung, ob sich z. B. die „keine Zeit habenden“ von den „kein Verständnis habenden“, im Hinblick auf sozialstatistische Merkmale unterscheiden, führte nicht zu relevanten Ergebnissen.

Tabelle 1. Interne Protokollierung der Ablehnungsgründe (Mehrfachnennungen) in % des Auftretens

Ablehnungsgrund	in %
Kein Verständnis für Untersuchung	16,1
X nicht belastbar, zu sensibel	11,1
Untersuchung kann X nicht zugemutet werden	9,9
Zeitmangel + kein Interesse für Untersuchung	8,1
Zeitmangel, aber prinzipielles Interesse an Unters	7,5
X ist normal, macht keine Schwierigkeiten	7,5
Kein Vertrauen in Datenschutz	6,8
X in Therapie wegen körperlicher Krankheit	5,6
Schlechte Erfahrungen mit Tests o.ä.	5,0
X ist krank	4,3
X lehnt Mitarbeit ab	4,3
Sprachschwierigkeiten der Eltern	3,7
Berufung auf Freiwilligkeit	3,1
X in Therapie wegen Verhaltensstörungen	2,5
Andere Personen haben abgeraten (Arzt, Lehrer)	2,5
Sonstige Gründe	1,8
	100%

Arbeitshypothese A

Eine Betrachtung der vorliegenden psychologischen Variablen der Schultestung (siehe Tabelle 2) läßt vermuten, daß die Verweigerergruppen nicht aus einer Grundgesamtheit stammen, sondern sich hinsichtlich psychologischer Testvariablen von den Teilnehmern unterscheiden.

Die teilnehmenden Kinder waren nonverbal (gemessen mit dem CFT) intelligenter als die Kinder der Verweigerergruppen. Auch im unmittelbaren Behalten (Zahlenfolgedächtnis aus PET) und hinsichtlich der kognitiven Impulsivität (modifizierter MFF-Test nach Geisel) und der visuomotorischen Gestalterfassung (gemessen mit dem GFT) schnitten die Kinder der teilnehmenden Eltern besser ab. Für die Lese- und Rechtschreibleistung gemessen mit dem Züricher Lesetest, trat kein Unterschied auf. Bei Alphaadjustierung erbringen nur GFT und MFF signifikante Unterschiede, andererseits ist auffällig, daß die Verweigerer in allen Testverfahren absolut geringere Leistungen zeigen als die Teilnehmer. Die Ergebnisse der unsystematischen Ausfälle auf dieser Stufe liegen vom Trend her zwischen den Teilnehmern und den Verweigerern.

Arbeitshypothese B

Tabelle 3 zeigt, daß die Kinder der Verweigerer in bezug auf bestimmte psychiatrische Symptome nicht auffälliger sind als die Teilnehmer. Für das Symptom „aggressive Handlungen, die zu Polizeikontakten geführt haben“ wurde das 5% Signifikanzniveau knapp verfehlt.

Bei einem Vergleich der Teilnehmer mit den Verweigerern des Familieninterviews hinsichtlich be-

Tabelle 2. Kritische F-Werte (Einweg-Varianzanalyse, SPSS-Breakdown) für Variablen der Schultestung

Variable		Teilnehmer			Unsystematische			ZI-Verweigerer			F	P	
		n	\bar{X}	s	n	\bar{X}	s	n	\bar{X}	s			
Wahrnehmung	CFT 1	205	11,48	1,13	14	10,71	1,32	23	10,95	2,09	3,97	0,0200	*
	CFT 2	205	10,09	1,59	14	10,35	1,86	23	10,00	1,88	0,21	0,8051	
Reasoning	CFT 3	205	8,08	2,00	14	7,21	1,84	23	7,97	1,80	2,36	0,0960	
	CFT 4	205	8,57	1,83	14	8,21	1,31	23	8,00	2,11	1,19	0,3054	
	CFT 5	205	9,90	2,36	14	8,71	2,55	23	8,47	3,23	4,62	0,0107	**
Allgemeiner IQ		205	105,22	13,04	14	98,57	11,53	23	99,34	17,60	3,30	0,0382	*
Visumotorische Gestalterfassung													
GFT		205	20,32	5,11	14	20,28	4,28	23	24,43	4,16	7,05	0,0011	***
Zahlenfolgedächtnis		206	28,35	8,37	14	23,64	5,27	23	24,43	6,13	4,35	0,0138	**
Leseleitung ZLT		207	1,07	1,22	15	1,06	1,09	23	0,86	1,14	0,29	0,7465	
Rechtschreibtest		207	22,65	7,96	15	21,53	9,67	23	19,95	8,78	1,20	0,3008	
bp-Richtige		200	103,98	28,72	12	95,41	20,30	22	101,31	30,38	0,56	0,5672	
Fehler im MFF		206	14,33	8,04	14	15,14	9,40	23	20,47	8,69	5,82	0,0034	***

stimmter Symptome zeigten sich folgende Ergebnisse, die wegen der geringen Fallzahl bei den Familieninterviewverweigerern nur als Trend interpretiert werden sollen. Die beiden Gruppen unterscheiden sich nicht in Bezug auf Symptome wie Einnässen, Einkoten, Tics und depressives Verhalten des Kindes, sondern hinsichtlich hyperkinetischer Symptomatik, Schulschwänzen, aggressive und antisoziale Handlungen.

Angesichts des sich andeutenden Trends bei den Familieninterviewverweigerern kann nicht ausgeschlossen werden, daß Dissimulationstendenzen bei den Gesamtverweigerern eine Rolle spielen.

Arbeitshypothese C

Es wurde ein Schichtindex konstruiert, der die Schulbildung beider Elternteile, das Berufsprestige beider Elternteile (Welz und Klug 1980) und das Familiennettoeinkommen berücksichtigt. Danach kann mit hinreichender statistischer Sicherheit ($P=0.003$) festgestellt werden, daß bei den Gesamtverweigerern ein größerer Anteil der unteren Mittel- und Unterschicht zuzurechnen ist als bei den Teilnehmern (Tabelle 4).

Zusammenfassend zeigt sich also, daß das Informations- und Kooperationsverhalten deutliche schichtspezifische Tendenzen aufweist, nicht jedoch die Begründung desselben, vor allem die der Verweigerung.

Weitere Ergebnisse

Interessant ist auch das Ergebnis, daß die Verweigerer weniger qm Wohnraum zur Verfügung haben als die Teilnehmer. Ungefähr ein Viertel der Verweigerer sind Alleinerziehende gegen 17% bei den Teilnehmern. Der Anteil an alleinerziehenden Vätern ist bei den Verweigerern höher als bei den Teilnehmern, jedoch nicht mehr signifikant. In bezug auf die gerade besuchte Klasse des Kindes läßt sich die Häufigkeitsverteilung auf drei Jahrgänge bei den Teilnehmern nicht bei den Verweigerern wiederfinden. Es ist zu vermuten, daß sich in der Gruppe der Verweigerer prozentual mehr Wiederholerschüler befinden als bei den Teilnehmern, was im Hinblick auf die Symptomliste auch Sinn gibt. Hinsichtlich der Anzahl der Personen im Haushalt und der Anzahl der Geschwister ergaben sich keine signifikanten Unterschiede.

Diskussion

Die Ergebnisse von Cox et al. (1977), daß die Kinder von Eltern, die nicht kooperieren, verhaltensauffälliger sind, sich aber in Bezug auf IQ nicht unterschei-

Tabelle 3. Absolute Häufigkeiten und % Anteile bestimmter Symptome für die Teilnehmer ($n=190$) und die Gesamtverweigerer ($n=55$)

Symptome	Teilnehmer	Ges.- Verweigerer	phi
Keine Beziehung zu Gleichaltrigen	3 ~ 1,5%	3 ~ 5,4%	+ 0,1067
Aggressive Handlungen Polizei bekannt	1 ~ 0,5%	2 ~ 3,6%	+ 0,118
Pathologische Ängste	8 ~ 4,2%	5 ~ 9,1%	+ 0,094
In der Schule introvertiert	3 ~ 1,5%	0 ~ 0%	- 0,057
Einnässen	10 ~ 5,2%	3 ~ 5,4%	+ 0,0035
Schulschwänzen	3 ~ 1,5%	0 ~ 0%	- 0,059
Schulangst	3 ~ 1,5%	1 ~ 1,8%	+ 0,007
Expansives Schulverhalten	2 ~ 1,0%	2 ~ 3,6%	+ 0,085
Stehlen	6 ~ 3,1%	0 ~ 0%	- 0,085
Hyperkinetische Symptomatik	11 ~ 5,7%	4 ~ 7,2%	+ 0,025
Lügen	31 ~ 16,3%	6 ~ 10,9%	- 0,053
		4:7 ns	

Kritische Schranke für Binomialtest $n=11$ bei 5% - Signifikanz: 2:9; (nach Sachs 1974, p 248)

Tabelle 4. Sozialstatistische Merkmale der Teilnehmer ($n=207$) und der Gesamtverweigerer ($n=55$)

	Teilnehmer	Verweigerer	
Schichtindex (Schulbildung, Berufsprestige und Nettoeinkommen der Familie Range 3-25)	≤ 13 92 > 13 107 $\bar{x} = 14,63$ $s = 4,96$	≤ 13 37 > 13 17 $\bar{x} = 12,05$ $s = 4,57$	$\chi^2 = 8,44$ $P = 0,003^{**}$
besuchte Klasse	1. 3 2. 83 3. 112	3 36 16	$\chi^2 = 13,86$ $P = 0,000^{**}$
Anzahl der Geschwister	keine 53 eines 88 zweit 58	14 21 20	$\chi^2 = 1,10$ $P = 0,25$
m ² Wohnfläche	≤ 100 110 > 100 80 $\bar{x} = 99,9$ $s = 38,0$	≤ 100 39 > 100 13 $\bar{x} = 86,4$ $s = 23,8$	$z = 3,12$ $\chi^2 = 5,04$ $P = 0,025^*$
Alleinerziehende	36 18%	13 24%	$P = 0,06$
- Vater sorgeberechtigt	3	4	Fisher exact
- Mutter sorgeberechtigt	33	9	$\chi^2 = 3,92^*$

den, konnten wir nicht bestätigen. Die Kinder der ZI-Verweigerer zeigten signifikant schlechtere Leistungen in bezug auf testpsychologische Parameter.

Den Grund für diese Diskrepanz der Untersuchungsergebnisse sehen wir hauptsächlich in der unterschiedlichen Verweigererquote, unsere von 38,5% gegen 8,4% von Cox. Da wir der Meinung waren, daß besonders hartnäckige Verweigererarbeit zwar die Quote senkt, nicht aber die Gültigkeit der Aussagen erhöht, nehmen wir diese hohe Rate in Kauf, die wir zum Teil darauf zurückführen, daß es uns trotz aller Bemühungen nicht gelungen ist, die soziale Distanz zu den Befragten adäquat zu überbrücken.

Wir schließen aus den Ergebnissen der Verweigereruntersuchung, daß bei einer hohen Verweigererquote die Tatsache der Verweigerung nicht direkt mit Verhaltensauffälligkeit des Kindes in Beziehung gesetzt werden kann, daraus folgt, daß die Gründe für die Kooperations- und Informationsverweigerung bei einer hohen Quote wahrscheinlich andere sind, als bei einer niedrigen, trotzdem sind Dissimulierungstendenzen anzunehmen. Diese Dissimulierungstendenzen und die Tatsache, daß über 7,1% der Gesamtstichprobe keinerlei Informationen erreicht werden konnten, läßt es möglich erscheinen, daß sich unter den konsequenten Verweigerern analog zu Cox et al. doch überdurchschnittlich viele Auffällige befinden. Bei einer insgesamt niedrigen Verweigererquote dürfte es sich dann um den „harten Kern“ der Verweigerer handeln, unter Umständen die Quote von Cox et al.

Schlußfolgerungen

Wir haben trotz unserer hohen Verweigererquote keine Hinweise dafür, daß die Prävalenz kinderpsychiatrischer Auffälligkeiten deutlich unterschätzt wird. Unter den Verweigerern finden sich nicht vermehrt Auffällige. Dieser Nachweis muß wegen der unterschiedlichen Teilnahmemotivation bei Studien mit hohen Verweigererraten jeweils spezifisch erbracht werden.

Danksagung. Herrn Dipl.-Psych. W. Reichert danken wir für die Mitarbeit bei der elektronischen Datenanalyse.

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W. H. Allehoff
Jugendpsychiatrische Klinik
Zentralinstitut für Seelische Gesundheit
J 5
D-6800 Mannheim
Federal Republic of Germany

Adversity and the onset of psychiatric disorder in women

P. G. Surtees and D. Rennie

M. R. C. Unit for Epidemiological Studies in Psychiatry, University of Edinburgh, Edinburgh, Scotland, UK

Summary. This report consists of a re-analysis of life event and illness onset data collected in community and hospital based studies of women in Camberwell, London. Previous analyses of this data by Brown and colleagues adopted a categorical approach, with a high threshold for deciding whether severe life stress had occurred. However, further practical and theoretical advances in investigating event-illness relationships may be achieved by considering an alternative conceptualisation of life stress. This report contrasts the results obtained by the categorical approach with those from one based upon a model of adversity incorporating assumptions both of additivity between events and of decay in their stressful effect over time. The results suggest that whilst the two methods are complementary in substantive terms, they convey markedly different practical and theoretical possibilities.

Introduction

During the 1960s, two distinct methods of assessing life stress were developed. One required an individual to indicate which (if any) of a specified list of events he had experienced within a particular time period, whilst the second was based upon a semi-structured interview technique. The list methods have been criticised for a number of methodological and theoretical reasons but predominantly because they transfer responsibility to the subject for deciding whether or not an event has occurred and the individuals to whom particular events on the list refer (e.g. see Brown 1981). The list, or respondent-based, methods have remained, in spite of fervent criticism, the method of choice for the majority of researchers during the last ten years.

There are a number of reasons why this may be. An event list is cheap to administer, takes only a small amount of time, little or no training on the part of the

interviewer using it and lends itself to the postal survey type of research. A further source of attraction to researchers is that it purports to provide an aggregate measure of the total life change, or distress, that an individual has experienced over a specified time period. This has been achieved in most of the list measures through the use of social consensus scaling (e.g. see Holmes and Rahe 1967). A particular event, such as marriage, is assigned a value prior to the scaling exercise and all other events are related to it. A single composite measure of 'stress' is then determined for any self-reported event set by the simple addition of their assigned weights. The availability of this measure facilitates the statistical manipulation of 'stress' in relation to other variables. However, because of the fundamental deficiencies in the method already indicated leading to measurement invalidity, the value of a single summary index is reduced.

The alternative approach to the measurement and assessment of life stress is one developed at Bedford College. This instrument, because it is investigator based and specifies in advance of the interview what can and cannot be included as stressors and (very importantly) the group of individuals that may be included, has considerably reduced the measurement invalidity associated with this work. The Bedford College instrument thereby not only distinguishes between stressors which meet the pre-established criteria and those which do not, but also enables contextual threat ratings to be made about every stressor. The approach however does not provide an overall measure of the life stress experienced as this was not a dominant objective in its development. For many purposes this is not a disadvantage but it may have contributed to its relative unpopularity in comparison to the list methods.

A theoretical underpinning to the interview approach is that which conceives of stressors in categorical rather than continuous terms. In consequence most, if not all, published work reporting upon the outcome of using the Bedford College instrument

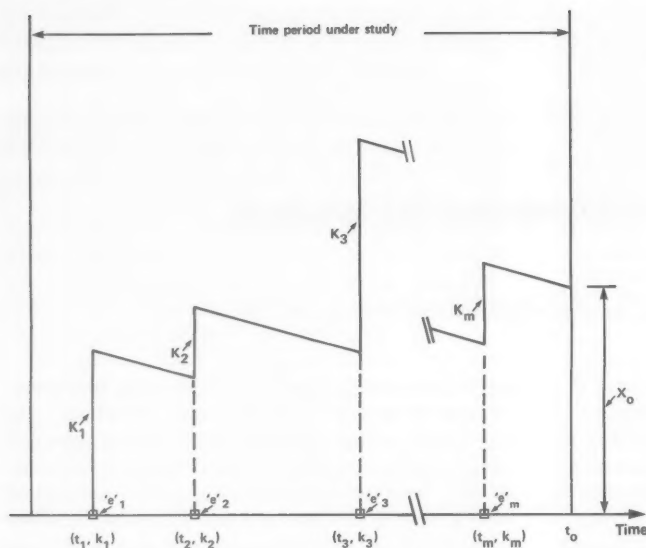


Fig. 1. Schematic representation of the linear decay in stressful effect of a series of life events ' e_1 ' to ' e_m '.

does so in a way which sets a presence/absence stressor boundary. Whilst considerable advances have been made through the imposition of such a categorical system, it is possible that further gains may be achieved by considering alternative conceptualisations of life stress scaling.

The present empirical study represents a re-analysis of data already widely reported (e.g. see Brown and Harris 1978) and concerned, in part, with examining the relationship between stressful life events and the onset of psychiatric disorder. It is the principal aim of this report to compare and contrast results obtained by traditional analyses using the categorical system, with those based upon a method which takes the same carefully determined event ratings but incorporates them within a decay model of life stress. This model attempts to provide a composite index of residual adversity due to the combined effects of different life events occurring at different times. Two postulates concerning life events were incorporated within the model. Firstly, that the stressful effect of a life event decays with time at a *constant* rate, with this rate being the same for all events, and secondly, that independent life events summate in their stressful effect. Figure 1 presents schematically the result of applying these postulates to a series of life events ($e_1 \dots e_m$) with time and stressful effects ($(t_1, k_1) \dots (t_m, k_m)$) etc., experienced by a particular individual.

The level of residual adversity (X_0) at time t_0 can be determined by combining the effect (k_m) of the last event before t_0 with the residual adversity at t_m due to preceding events and then allowing for event decay. The model has been described in more detail elsewhere (Surtees and Ingham 1980).

Whilst the model has now been tested on event data in a number of studies investigating life stress – symptom state relationships (Surtees 1980; Surtees et al. 1981) no opportunity has been available until now to examine its use in relation to the *onset* of psychiatric disorder. This study therefore set out to examine the relative merits of categorical and continuous life stress measures in relation to the onset of psychiatric illness.

Material and methods

During the years 1969/71 and 1974/75 two community surveys of women were undertaken in the London borough of Camberwell. The combined surveys provided material on 458 women, of whom 39 were considered to be chronic psychiatric cases and were therefore not included in any of the analyses to be presented in this report. Of the remaining sample of 419 women, 37 experienced an onset of psychiatric illness (depression with or without anxiety) at some time during the year covered by the interview. Full details regarding design and sampling methodology have been reported elsewhere (Brown and Harris 1978).

To complement the community survey samples, two hospital based patient samples were obtained from women who were resident in Camberwell. An in-patient sample of 73 women and an out-patient sample of 41 women were selected from admissions to and attendance at a number of London hospitals. All patients had recently contacted a psychiatrist for depression and were included in the study if there had

Table 1. Bedford College life event ratings with their decay periods in weeks relative to those assigned to the most severe event. Relative event weightings are also shown

Life event ratings		Assigned decay periods, in weeks, with the most severe event over in;			Event weightings in relation to that of the most severe event
Long-term threat (LT)	FOCUS 'S' = Subject focussed 'O' = Other focussed	6 months	1 year	∞ (No decay)	
1	'S'	26	52	∞	1
1	'O'	19.5	39	∞	0.75
2	'S'	13	26	∞	0.5
2	'O'	9.75	19.5	∞	0.375
3	'S'	6.5	13	∞	0.25
3	'O'	4.875	9.75	∞	0.1875
4	'S'	3.25	6.5	∞	0.125
4	'O'	1.625	3.25	∞	0.0625

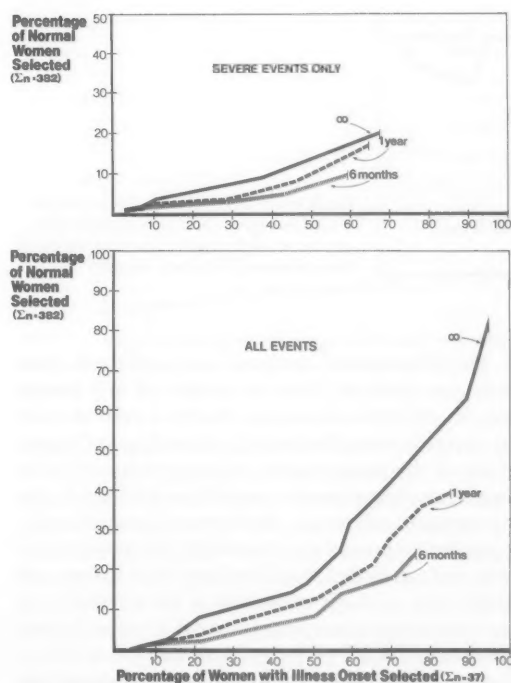


Fig. 2. The relative rate of selection of women with illness onset to those without, determined according to their ranked level of residual adversity at onset or interview. Event class and maximal decay periods were varied as shown

been a significant change in their clinical condition during the year before hospital admission or first outpatient contact. Further details concerning sampling and patient characteristics have been reported elsewhere (Brown et al. 1973; Brown and Harris 1978).

Detailed information was obtained from all the women participating in the studies concerning, amongst many other items, the nature and timing of all stressful life events that they had experienced dur-

ing the year prior to interview using the Bedford College instrument. In addition, all women were given a modified form of the Present State Examination (Wing et al. 1974) covering the entire study period prior to interview, which in conjunction with an onset schedule enabled the dating of clinical state change points.

Results

In order to test the decay model upon the Camberwell data, a decision had to be taken concerning the way in which life events with Bedford College ratings should be incorporated within the model. After discussions with Brown and colleagues, it was agreed that those event ratings given greatest emphasis for describing event severity, namely long-term threat (LT) and event focus (F), should be those directly linked to the postulates of the decay model.

Ratings of long-term threat are made on a four point scale ranging from 1 (marked), 2 (moderate), 3 (some), 4 (little or none), by considering both the context in which the event occurs and the likely meaning of the event for the individual who has experienced it. The ratings are intended to indicate the threat implied by events about one week after they have happened. The event focus rating is intended to indicate who was involved in the event. Main emphasis on research already reported upon divides the focus rating according to whether the subject alone, or the subject and some other were jointly involved in an event ('S' focussed) or whether some other person was the main focus of the event ('O' focussed). Combining LT and F ratings provides the eight rating combinations shown in Table 1.

In earlier reports (Surtees 1980; Surtees and Ingham 1980) an algorithm was utilised which assigned weights to events according only to their Bedford College threat ratings. This provided a 16 fold variation in weighting between the most and least severely rate

Table 2. Maximum percentage of onset cases selected according to ranked measures of residual adversity determined by varying event class and decay periods. The percentage of normal women selected is also shown

Event class	Decay period assigned to most severely rated event	Percentage of normal women selected ($\Sigma n = 382$)	Percentage of onset cases selected ($\Sigma n = 37$)	Onset case: normals selection rate ratio
Severe events only	6 months	9.4%	59.5%	6.33 : 1
	1 year	16.8%	64.9%	3.86 : 1
	∞ (no decay)	19.6%	67.6%	3.45 : 1
All events	6 months	23.8%	75.7%	3.18 : 1
	1 year	38.7%	83.8%	2.17 : 1
	∞ (no decay)	80.6%	94.6%	1.17 : 1

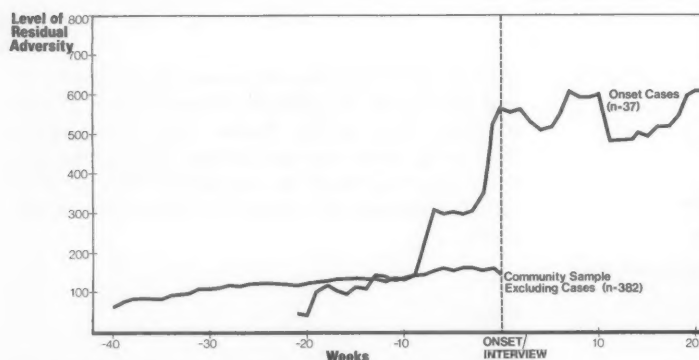


Fig. 3. Mean level of residual adversity for weeks preceding and following time of illness onset (community cases) and preceding time of interview (normal women)

events. It was decided to retain this range in assigned weights when event focus was included in the analyses. In consequence, events with specific Bedford College threat and focus rating combinations were assigned the weights shown in Table 1.¹

One of the postulates of the decay model dictates that the *rate* of decay of event stress is constant for events of all severities. In order to incorporate this within the present analysis and to additionally investigate the relative importance of decay as an event property, both decay and no decay conditions were assigned to all events. These are shown in detail in Table 1. Only two decay conditions were considered. The first retained the relationship between event decay periods used in previous analyses, i.e. the most severely rated event having a decay period of 26 weeks (6 months), the least severe event ($LT = 4$, $F = 'O'$) being over in about 11 days. The second condition doubled the time period taken for the stressful effect of events to be completely over (rate of decay halved), thus the effect of the most severely rated event would now be over in 1 year.

¹ Alternatively the weightings shown in Table 1 for those events with 'S' focussed ratings can be represented by the integers 16, 8, 4, 2 whilst the intermediate integers 12, 6, 3 represent the upper three threat levels of 'O' focussed events. The least severe event, with an assigned weighting of one, retains the 16 fold variation in weighting used in earlier analyses.

The initial set of analyses was performed upon event data obtained from the sample of 419 women interviewed in the community studies. Levels of residual adversity were determined, according to the postulates of the decay model, for every woman in the sample, at illness onset or interview whichever was appropriate. Only events which were classified as 'independent or possibly independent' of any illness episode were included in all analyses (see Brown and Harris 1978, p 74). Computation of the adversity values was varied according to event severity (severe events only, i.e. $LT = 1$ any focus, and $LT = 2$, $F = 'S'$ or all events) and according to the event decay parameters described (the most severely rated event over in 6 months, or 1 year or no decay). The residual adversity values determined by each of the 6 analyses were then ranked (high values to low) and the relative rate of selection of the onset cases to normal women determined. The result of performing these analyses is shown in Figure 2.

Whilst the configuration of the two sets of curves shown in Figure 2 is broadly the same, the analyses yielded markedly different case: normal selection rate ratios. These are summarised in Table 2.

As shown in Table 2, the inclusion of an event decay parameter, whilst slightly reducing the proportion of women selected who had experienced an illness onset, considerably reduced the proportion of normal

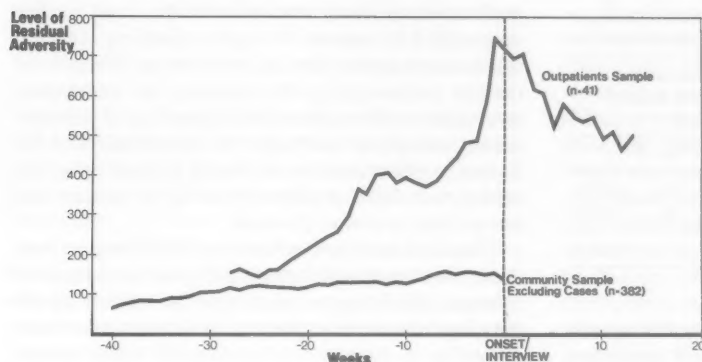


Fig. 4. Mean level of residual adversity for weeks preceding and following time of illness onset (hospital out-patients) and preceding time of interview (normal women)

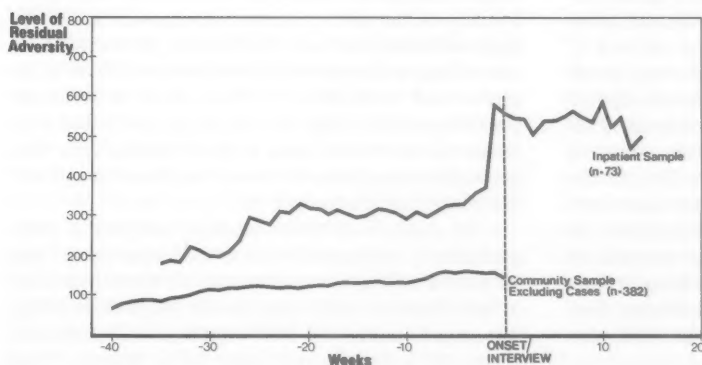


Fig. 5. Mean level of residual adversity for weeks preceding and following time of illness onset (hospital in-patients) and preceding time of interview (normal women)

women selected in contrast to when event decay was not allowed. A comparison of these results with those obtained when the sample is divided according to their experience or not of severe events is possible by re-examining Figure 2. As can be seen (from the severe events only, no decay curve) the experience of at least one severe event during the pre-onset or appropriate pre-interview period selects 67.6% of onset cases ($n = 25$) to 19.6% of normal women ($n = 75$), a selection rate ratio of 3.45:1. If the analysis is confined to severe events only and their stressful effect is assumed to decay with the passage of time, then although the overall selection rate ratios increase considerably beyond that of the no decay condition, it remains impossible to select as many onset cases as when no event decay parameter is included. If, however, all illness independent events are included in the analysis, then selection rate ratios can be determined at that level of residual adversity which selects the same number of onset cases (67.6%) as under the no decay condition. From Figure 2 (all events) with one year decay assigned to the most severely rated event, the ratio is 2.66:1, whilst with 6 months assigned the ratio is 3.95:1. For optimal overall selection of onset cases to minimal overall selection of normal women,

the above analyses suggest that a 6 month decay period assigned to the most severely rated event is most appropriate and that all illness independent events should be included in the analysis. It is therefore on this basis that the next set of analyses were undertaken.

Of particular interest in life stress research is the nature of the relationship between life events and illness. So often this has rested on examining correlations between event list scores and symptom severity measures. Few published studies exist, apart from those cited in connection with the samples considered here, that have attempted to examine life events in relation to the onset of carefully validated psychiatric illnesses. The next stage of analysis undertaken was therefore to examine the relationship between residual adversity and the onset of illness amongst the various samples available. The first analyses were performed upon the community sample of 419 women.

The mean level of residual adversity due to all illness independent life events was determined, using the decay model, for each of the weeks preceding and following the time of illness onset for the community sample of women who had become ill at some stage during the study period. Mean adversity levels were

Table 3. Proportions of women with onset of caseness in year by intimacy context and whether they had experienced a severe event

		One or more severe events experienced before onset of illness or interview	
		Yes	No
Intimacy context	'a'	$\frac{7}{51}$ (13.7%)	$\frac{4}{230}$ (1.7%)
	'non-a'	$\frac{18}{49}$ (36.7%)	$\frac{8}{89}$ (9.0%)
		(25.0%)	(3.8%)

also determined for those women not suffering any illness onset, in their case for each week preceding interview. The results are shown in Figure 3.

For the sample experiencing illness, Figure 3 reveals an initial rise in mean adversity levels about seven weeks before onset and the apparent absence of any delay between a further rise in adversity levels and the timing of the illness onset. The results also reveal that at illness onset, the mean level of residual adversity is almost four times that of the remainder of the community sample at interview. The results shown in Figure 3 also clearly validate the interviewing procedure of the Bedford College instrument, in that the mean level of adversity for the community sample normals remains relatively unchanged over many months preceding interview. Problems associated with the recall of events which occurred distant to the interview appear to be few.

As described above, a hospital based study was also undertaken in which life event information was obtained from 41 out-patients and 73 in-patients. The date of onset of illness was also determined. Analyses performed upon the community sample were now repeated, firstly upon the out-patient sample and secondly upon the in-patients. The results are shown in Figures 4 and 5 with those obtained from the community sample normals for comparison.

Figure 4 reveals that mean adversity levels peak close in time to onset of illness and drop following onset. Additionally, the out-patients had a mean adversity level at onset just over five times that of the community sample at interview. For the in-patients (Fig. 5), onset of illness again shortly follows the mean

peak adversity level reached and this level is then maintained for almost 15 weeks, equalling the average time to hospital admission following illness onset for this patient group. In addition, the maintained level of adversity is about four times that of the community sample at interview. An examination of the figures together also reveals that at 15 weeks post-onset the mean level of adversity for the in-patients and out-patients is almost identical.

The final analyses undertaken for this report were those concerned with determining the importance of intimate, confiding relationships for women by examining their recent exposure to life stress either categorically, or dimensionally using the decay model. For this exercise the data available from the combined community sample of 419 women were used. Initially all the women were cross-classified, according to whether they had experienced one or more severe events in the period before onset of illness or interview and by whether they had a close and intimate confiding relationship ('a') or not ('non-a'). The proportion of women in each of the resulting cells who had experienced onset of illness was then determined. The results are shown in Table 3.

The analysis of cross-classified categorical data, particularly in respect of theoretical issues concerning vulnerability hypotheses, has recently been the source of considerable controversy in the psychiatric literature (e.g. Tennant and Bebbington 1978; Brown and Harris 1978; Everitt and Smith 1979; Surtees 1980; Duffy 1981). Much of this controversy has arisen through disagreements concerning the appropriateness or otherwise of the statistical models which underly the procedures used to analyse cross-classified data. From recent developments it would appear that the resolution of the vulnerability hypothesis will only be achieved through further studies, with perhaps prospective investigations holding greatest promise, and through the provision of statistical procedures which test for scale-free interaction. Such statistical models would have the advantage of not depending on scales of measurement (e.g. linear, log-linear or logistic). However in the present context these issues were not the main focus of attention. This investigation set out to determine whether there was any ad-

Table 4. Proportions of women with onset of caseness in year by intimacy context and level of residual adversity

		Level of residual adversity at onset of illness or interview			
		≥ 1000	$< 1000 \geq 500$	$< 500 > 0$	0
Intimacy context	'a'	$\frac{3}{9}$ (33.3%)	$\frac{1}{14}$ (7.1%)	$\frac{4}{65}$ (6.2%)	$\frac{3}{193}$ (1.6%)
	'non-a'	$\frac{3}{9}$ (62.5%)	$\frac{4}{12}$ (50.0%)	$\frac{3}{55}$ (25.7%)	$\frac{8}{83}$ (7.2%)
		(47.1%)	(26.9%)	(13.0%)	(3.3%)

vantage to be gained from aetiological or theoretical standpoints, if the categorical measure of life stress was replaced by a continuous one based upon the decay model. As can be seen from Table 3, the imposition of a single stressor boundary, whilst suggesting that confidant intimacy may act as a protective agent, does not facilitate the determination or investigation of the range of adversity against which it provides protection.

As a preliminary investigation of this issue, the categorical measure of life stress was replaced by levels of residual adversity (based upon all 'illness independent or possibly independent' life events and with the most severely rated event having an assigned decay period of 6 months) at the time of illness onset, or interview if no onset occurred. The results are shown in Table 4.

To illustrate some of the possibilities inherent in applying the decay model, four distinct levels of residual adversity were chosen. These levels have some correspondence with the Bedford College ratings.² The most important point here is that these levels of residual adversity are those remaining, after allowing for event decay due to the passage of time, at illness onset or interview. The proportion of women suffering illness onset within each of the cells of Table 4, as in Table 3, suggests that confidant intimacy may act as a protective agent. However, Table 4 provides more information to demonstrate that with increasing levels of adversity the proportion of women experiencing illness onset also increases, reaching 47% of those with the highest levels of residual adversity. The table reveals a consistent increase in proportions experiencing illness onset for the group without a close confidant. It also indicates that the degree to which protection was provided by a close confidant was less marked when residual adversity levels were greater than, or equivalent to, that of the most severely rated Bedford College event occurring exactly at the time of onset or interview.

Discussion

This report has been concerned with investigating the relationship between stressful life events and the onset of psychological illness by adopting alternative approaches to quantifying life stress. As a result, the study additionally provided an opportunity to examine the value of certain event parameters mostly neglected in life stress research.

² A level of exactly 1000 units is equivalent to women having experienced the most severely rated event ($LT=1$, $F='S'$) precisely at the time of illness onset or interview. In the same way $< 1000 > 500$ units corresponds to events rated within the range ($< LT=1$, $F='S' > LT=2$, $F='S'$) whilst $< 500 > 0$ units corresponds to the event range ($< LT=2$, $F='S' > LT=4$, $F='O'$).

The first set of analyses were concerned with assessing the discriminatory power of categorical and continuous stress measures, under conditions when event class was varied and when the time period for which events had influence was limited, or not. The resulting analyses revealed the relative rates with which cases could be selected to non-cases where a continuous stress measure was utilised, and the particular selection rate ratio obtained when a categorical system was applied. The results indicated that the ratio of cases selected to non-cases was increased when events were allowed to decay in contrast to when decay was not assumed, *regardless of the class of events* included in the analyses. In addition case: non-case selection ratios obtained through use of the continuous measure could be shown to exceed that achieved by the categorical system.

Further analyses using the decay model clearly demonstrated the close association between mean peak level of adversity and the onset timing of illness. These results were in accord with those obtained when the rate of severe events was plotted before illness onset (e.g. see Brown and Harris 1978). However the study has additionally demonstrated that levels of adversity remain high following illness onset for women who become in-patients, whilst for out-patients, levels decrease somewhat following onset.

The value of imposing a categorical system based upon Bedford College instrument ratings is now firmly established. However, this study set out to determine whether further practical and theoretical advantages can be conveyed through the use of those same carefully determined event ratings, within a model which includes decay and additivity as event properties.

The investigation of these event properties in isolation remains difficult. Iterative analyses already reported upon (Surtees et al. 1981) between adversity levels determined when event decay periods were varied, and measures of symptom severity, have suggested the value of allowing the stressful effects of events to decay with time. The results obtained in this report have also shown that regardless of the class of events included in analysis, case: non-case selection ratios are numerically greater when allowance is made for event decay. Additivity between events remains controversial. The evidence so far is that if passage of time is neglected, then minor events alone or in combination with severe events, contribute little in distinguishing between women with onset of illness and those without onset. However, multiple discrete and illness independent severe events do appear, even without considering time, to slightly increase the risk of illness onset (Brown and Harris 1978, p 108).

The results shown in Figure 2 of this study emphasise that it is only when the stressful effect of events is allowed to decay with time, that minor events play

any important role in combination with severe events in distinguishing between those with and without illness onset. Such minor events are illness independent and by definition must occur close in time to onset to have any effect. These results therefore provide further evidence against the simple addition of event weights used in many of the event list techniques.

The findings of this study provide empirical support for the decay model, but it is important to indicate the advantages that may accrue from its adoption in future analyses. The availability of a measure of adversity which can be determined for *any* time within a study period, does facilitate the investigation of adversity in relation to changes in health or treatment. It is therefore possible to examine event-illness relationships in population samples not only on the basis of adversity values determined at a time common to the entire sample, but also (for instance) in relation to the period for which, and the severity at which, adversity levels are maintained. In addition, the decay model will facilitate investigations designed to reveal the relationship between the peak level of adversity *ever reached* (within a study period) and its timing in relation to illness onset or interview.

The determination of the role of adversity in association with social factors for illness onset may be facilitated by a continuous measure of adversity. The final analyses presented for this report revealed not only the range of adversity for which protection from illness onset was afforded by an intimate relationship, but how levels of residual adversity could be translated into equivalent Bedford College ratings at the time of illness onset or interview. It is important to note however that this report has been concerned only with event based adversity values, long term difficulties were not considered. These were excluded as, by definition, they are a different class of stressor and in consequence are likely to differ from events in the properties which govern their relationships both to each other, and to events. However, it may be possible in the future to apply the concept of decay to difficulties, if it can be established that individuals adapt, albeit slowly, to their effects.

At a more speculative level, the model may actually provide the means for testing theories regarding the nature and relationship of psychosocial factors to illness. For example, it is possible that sudden changes (or discontinuities) in health state may occur given certain combinations of social and individual factors (as in a cusp catastrophe surface model). The detection of the factor levels precipitating these changes is more likely to be successful using a continuous measure of adversity than without.

Further developments could also arise from an interpretation of event decay periods. Evidence is already available (Surtees et al. 1981) which suggests that event decay periods may provide a basis for detecting how populations differ in 'coping' with stress. Using the Bedford College instrument, life events are rated for their threatening implications only after careful consideration of the context in which they occurred. It is now clear that with further assessment of event and individual factors, estimates could be made from interview-based material, of the time period for which many events retain a stressful effect. An attempt is being made to achieve this in a community prospective study being undertaken in Edinburgh.

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Prof. P. G. Surtees
MRC Unit for Epidemiological Studies in Psychiatry
Edinburgh University Department of Psychiatry
Royal Edinburgh Hospital
Morningside Park
Edinburgh EH10 5HF
Scotland, UK

Adolescents' attitudes towards mental illness: relationship between components and sex differences

Ross M. G. Norman¹ and Ashok K. Malla²

¹Division of Community Medicine, Memorial University of Newfoundland, St. Johns, Newfoundland and

²Department of Psychiatry, University of Western Ontario, London, Ontario, Canada

Summary. Using a vignette format, components of attitudes towards mental illness were assessed in 413 high school students. The results suggest that while attitude components are generally not highly related, perceived severity of mental illness is positively related to attribution to physical causes, and negatively related to social acceptability. Beliefs in psychosocial etiology and psychosocial treatment correlate positively with optimistic beliefs about prognosis. Belief in the appropriateness of psychosocial treatment is also related to greater social acceptance of the mentally ill, whereas belief in medical treatment is negatively related to social acceptance. Additional data suggest that differences between males and females in their social acceptance of the mentally ill may be related to differences in beliefs about psychosocial etiology and perceived appropriateness of psychosocial treatment.

The research to be reported in this article addresses two issues. One issue is the relationships among various aspects of beliefs about and reactions to mental illness. In particular, it examines beliefs about the etiology of mental illness, its proper method of treatment, perceived prognosis, and the preferred level of social distance towards the mentally ill. Secondly, the data provide further evidence on the relationship between an individual's sex and his or her beliefs about and reactions to mental illness. Both of these issues are addressed by data collected on a sample of over 400 high school students.

Reviews of the considerable body of research literature on attitudes towards mental illness (Rabkin 1972, 1974; Segal 1978) reveal that most of the work done in this area describes various factors which influence attitudes concerning the mentally ill (e.g. demographic and personality characteristics of respondents, cultural factors, characteristics of the men-

tally ill and their behaviour etc.), and the effects of different types of education programmes on attitudes towards mental illness. There is comparatively little information on the relationship between the various components of attitudes towards the mentally ill within a given population. Nunnally (1961) presents evidence from a factor analysis of the questionnaire used in his rather extensive study which suggests that public information about mental illness is not highly structured, but aside from this observation the entire issue of the interrelationships between the components of attitudes about mental illness has received very little attention. Research in other areas has suggested that an understanding of the relationships between the components of attitudes can be helpful in developing effective techniques for changing attitudes (Rokeach 1968), and in determining whether attitudes will be stable and/or related to behaviour (Converse 1970; Norman 1975). In comments at the end of her extensive review of the relevant literature, Rabkin (1974) also emphasizes the need for more extensive study of the relationships between various components of attitudes toward mental illness. As Rabkin remarks "... it is quite clear by now that attitudes toward mental illness include several components, some of which are a function of relatively enduring personality traits such as authoritarianism, while others are related to more accessible dimensions such as educational exposure. Mental health campaigns are apt to influence only those attitudinal components associated with information level, such as beliefs about psychiatric etiologies ..." (Rabkin 1974, p 29). We need more understanding, therefore, of how the beliefs which are the target of education campaigns are related to other aspects of attitude toward mental illness.

There is, for instance, a considerable controversy as to whether educational campaigns should emphasize a medical or a psychosocial model of mental illness (Crocetti et al. 1972; Farina et al. 1978; Sarbin

and Mancuso 1970). Implicit in much of this debate is the notion that public beliefs about the etiology of mental illness have some influence on other dimension of attitude or belief concerning mental illness, such as social distance or assumed prognosis. There is, however, little if any empirical evidence that such a relation exists. The data collected in this study will allow an examination of the interrelation between various beliefs about mental illness such as etiology, beliefs about effective treatment, prognosis and preferred social distance.

A more careful examination of the components of attitudes toward mental illness may also help clarify how certain factors have their influence on reactions to the mentally ill. For example, some variables may have their predominant effect on perceptions of whether someone is ill, others may influence assumed etiology or prognosis. Any of these factors may or may not in turn effect the social distance maintained toward the mentally ill.

Sex is one easily assessed respondent characteristic which researchers have related to reactions to mental illness. Some studies (e.g. Bord 1971; Brockman and D'Arcy 1978) have found no differences in the reactions of men and women to mental illness. Other studies (e.g. Farina and Hagelaver 1975; Farina et al. 1978) have found evidence that women are more accepting of former mental patients than men. It is hoped that the current study will clarify some of the confusion concerning sex differences by systematically assessing the effects of sex of respondent and sex of the target person on varying types of beliefs about and reactions to the mentally ill. Such a procedure should help us more clearly identify the particular focus of any sex differences that occur in reactions to the mentally ill.

Method

Subjects

The subjects were 413 students in randomly selected classes of three high schools in St. John's, Newfoundland. There were 306 males and 107 females in the sample. All students were in grade 11 with a modal age of 16.

Procedure

The procedure used for collection of data was a variation of the vignette approach pioneered by Star (1955). As Brockman et al. (1979) concluded after a critical survey of methods used in this area, vignettes have the advantage of allowing respondents to react in a comparable format to concrete situational behaviour under circumstances that allow a great measure of experimental control.

Each class was asked by a teacher to complete an 8 page inventory during class time. While the classes used had not been asked to volunteer for the study, they were told that individuals would not be penalized for refusing to participate. All members of the classes approached did complete the questionnaire.

The inventory was introduced as being designed to measure opinions about mental illness and the mentally ill. Respondents were assured of anonymity and did not have to place their names on the questionnaire. Students were asked to provide certain demographic information including their sex on the first page. Six randomly ordered vignettes were presented to each respondent on separate pages of the questionnaire. The six vignettes were made up of three types of behaviour which were attributed to either a male or female target person. The vignettes were adopted from Yamamoto and Dizney (1967) and were intended by those authors and/or previous sources (Phillips 1963, 1964; Star 1955) to describe paranoid schizophrenic (PS), schizotypal personality disorder (PD)¹ and healthy (H) behaviour. No psychiatric labels were presented in the actual questionnaire. The descriptions for the three types of behaviour are as follows (the appropriate gender changes were made when the target person was intended to be female):

Paranoid Schizophrenic (PS): Here is a brief description of a young man. Imagine that he is a respectable student attending your school. He is very suspicious; he doesn't trust anybody, and he is sure everyone is against him. Sometimes he thinks that people he sees on the street are talking about him or following him. A couple of times he has picked fights with people who don't even know him, because he thought they were spying on him and plotting against him. The other night he began to curse his mother terribly, because he said she was working against him too – just like everybody else.

Personality Disorder (PD): Here is a brief description of a young man. Imagine that he is a respectable student attending your school. He is very quiet, he does not talk much to anyone – even in his own family. He has never participated in any kind of student activities and does not seem to want to do so. He acts like he is afraid of people, especially young women his own age. He does not go out with anyone and, whenever someone comes to visit his family, he stays in his own room until they leave. He just stays by himself and day-dreams all the time, and shows no interest in anything or anybody.

Healthy (H): Here is a description of a young man. Imagine that he is a respectable student attending your school. He accepts both happy and unhappy emotions freely and expresses his feelings and opinions openly. He is easy to get along with and others seek his company, knowing that he is generally pleasant. He plans ahead, thinks clearly, and is usually keen to learn.

Each of the six description was followed by nine questions to be answered by a seven point rating

¹ Originally the term used to describe the behaviour in this description was simple schizophrenia. This term is no longer used in D.S.M. III and we have therefore substituted the nearest diagnostic category now in use – schizotypal personality disorder.

scale anchored by the extremes "definitely yes" (1) to "definitely no" (7).

The first question asked whether the person described was mentally ill. The next set of three questions asked:

Is this person's behaviour the direct result of:

- a. Physical causes (such things as the condition of the person's brain and nervous system and what has been inherited from his parents)?
- b. Present life circumstances (home life, relations in school or work etc.)?
- c. Past experience (what happened to him and how he felt as a child)?

Each of the three above options about the cause of the person's behaviour was rated on the seven point scale. The average correlation between responses to (b) and (c) was judged sufficiently high ($r = 0.46$) to justify combining them into a single scale of psychosocial etiology.

The final five question asked of each vignette were designed to measure social distance. They took the form:

If you knew this person would you:

- a. Speak to him if you passed him on the street?
- b. Have lunch with him?
- c. Do school work with him?
- d. Go to a party at his home?
- e. Invite him to your home for an evening?

The average intercorrelation of these five scales ($r = 0.66$) was judged sufficiently high to justify combining them into a single social distance scale.

On the final page of the questionnaire respondents were asked their *general* opinions about mental illness and the mentally ill. They responded to each of the following items using the seven point scale already described.

1. Should a mentally ill person be treated by:

- a. Drugs and pills?
- b. By talking to him or her?
- c. By talking to his or her family?
- d. By encouraging the patient to talk about his or her feelings?
- e. By improving their financial situation?
- f. A medical doctor only?

2. A person who becomes mentally ill can return to normal.

Items 1 (a) and (f) ($r = 0.12$) were combined into a single scale for medical treatment and items 1 (b), (c) and (d) (average intercorrelation = 0.40) were combined into a single scale for psychosocial treatment. Item 1 (e) was not found to be related to any other items, nor were there any significant effects on this item for any of the analyses reported. For these reasons, there will be no further discussion of item 1 (e).

Results and Discussion

The three types of behaviours described in the vignettes did differ significantly in the ratings of mental illness perceived to be present. A three-way analysis of variance was performed on ratings of mental illness using sex of respondent as a between subjects factor and type of behaviour and gender of target person as repeated factors. The only effect to reach significance was type of behaviour ($F(2,804) = 439.03$ $p < 0.001$). The mean ratings of perceived mental illness in descending order are paranoid schizophrenic (4.7), personality disorder (3.4) and healthy (1.5).

Part I: Relationship Between Attitude Components

There were primarily seven components of attitudes toward mental illness which were assessed in this study. These were:

1. perception of a behaviour as indicative of mental illness;
2. belief in physical etiology;
3. belief in psychosocial etiology;
4. social distance;
5. belief in medical treatment;
6. belief in psychosocial treatment and
7. anticipated prognosis.

The average intercorrelations of the six components for the four vignettes (PS and PD) designed to portray disturbed behaviour are presented in Table 1.

One's first impression of Table 1 might be that with a few exceptions there is relatively little relationship between the components of attitudes toward mental illness. A careful examination of the statistically significant correlations in Table 1 suggests that there is, however, support for the following propositions:

1. Not surprisingly, the more an individual is judged to be mentally ill, the greater the social distance desired with reference to that person ($r = 0.23$).

2. The more a behaviour is seen as indicating mental illness, the more likely it is to be attributed to physical causes ($r = 0.30$). Perception of physical etiology is not significantly related to any other variable including preference for medical treatment.

3. Belief in psychosocial etiology is positively related to preference for psychosocial treatment ($r = 0.21$), and both of these variables are in turn positively related to belief in optimistic prognosis ($r = 0.14$ and 0.28 , respectively). Belief in medical treatment is related to negative perceived prognosis ($r = 0.19$).

4. Respondents who favour medical treatment for mental illness show greater social distance to those considered mentally ill ($r = 0.13$). On the other

Table 1. Average intercorrelations of attitude components

	Perception of mental illness	Physical etiology	Psychosocial etiology	Social distance	Medical treatment	Psychosocial treatment
Perception of mental illness						
Physical etiology	0.30*					
Psychosocial etiology	-0.01	0.03				
Social distance	0.23*	0.04	-0.07			
Medical treatment	0.10	0.07	-0.10	0.13*		
Psychosocial treatment	-0.03	0.00	0.21*	-0.15*	-0.24*	
Prognosis	-0.09	0.00	0.14*	-0.13*	-0.19*	0.28*

* $P < 0.01$, in order to minimize the likelihood of type 1 statistical error, a probability level of 0.01 has been used for statistical significance

hand, those favouring psychosocial treatment show less social distance and therefore more acceptance ($r = -0.15$).

5. There is a tendency for those who favour psychosocial treatment for mental illness not to favour medical treatment ($r = -0.24$).

6. Optimistic belief about prognosis is related to social distance ($r = -0.13$). Those who believe that a mentally ill person can return to normal maintain less social distance.

These findings imply that the more a person's behaviour is perceived as "mental illness", the less likely he/she will be socially acceptable and that such behaviour is likely to be ascribed a physical etiology. Furthermore, belief in medical/physical etiology of mental illness is not positively related either to perceived prognosis for or increased social acceptability of the mentally ill. Indeed, a belief in medical treatment is negatively related to social acceptance of the mentally ill. On the other hand, belief in psychosocial aspects of mental illness particularly with reference to etiology and/or treatment seems to have a more positive relationship with social acceptability of and optimism about prognosis for mental illness.

These findings do not demonstrate a causal relationship and some relevant correlations, although significant, are only moderate. They do, however, point out relationships between components of attitudes and beliefs that need to be considered seriously when planning mental health campaigns. The data

presented suggest caution concerning any attempt in education campaigns to present a primarily or totally medical model of mental illness.

Nunnally has suggested that information the public possesses about mental illness is not highly structured (Nunnally 1961), and this appears true for respondents in the present study. There is some evidence of apparent incongruity in the direction of beliefs and attitudes. For instance, perception of severity of mental illness is related to physical etiology, but beliefs in physical etiology are not related to beliefs in medical treatment. There is more congruity in beliefs and attitudes relating to psychosocial aspects of mental illness. This may reflect a need for greater sophistication in understanding the role of medical treatment in mental illness as well as its psychosocial aspect. It is possible that if education campaigns gave more extensive and accurate information based on a multi-modelled approach to mental illness (particularly emphasizing its psychosocial aspects) one might see a shift in public attitudes in the direction of greater social acceptance of the mentally ill.

Part II: Sex Differences in Reaction to Mental Illness

Each of the ratings concerning the six vignettes was subjected to a three way analysis of variance using sex of respondent as a between subjects factor and type of behaviour and sex of target person as repeated factors. Ratings of general attitudes toward mental illness (concerning treatment and prognosis) were compared for male and female respondents by means of a t-test. Relevant mean scores are presented in Table 2.

Male and female respondents did not differ significantly in their tendency to perceive particular behaviours as being indicative of mental illness. Female adolescents did, however, show greater social acceptance than males of the individuals portrayed in the vignettes ($F(1,401) = 24.71, P < 0.001$). The mean social distance score for males was 3.1 and for females it was 2.5. This finding is consistent with earlier findings by Farina and colleagues (Farina and Hagelaver 1975; Farina et al. 1978).

The sex of respondent x type of behaviour interaction and sex of respondent x sex target person interactions on social distance were also statistically significant. This suggests that the effect of one variable in each interaction was influenced by the level of the other variable. Relevant comparisons of individual means revealed that the difference between male and female adolescent respondents was only significant for behaviour intended as paranoid schizophrenic or personality disorder. Male and female respondents did not differ in social distance maintained toward persons showing healthy behaviour.

Table 2. Summary of mean scores on attitude components of male and female respondents

Attitude component	Mean scores		Significance test
	Male	Female	
Perception of mental illness ^a	3.2	3.1	$F(1,402) = 2.55$, ns
Belief in maintaining social distance	3.1	2.5	$F(1,401) = 24.71$, $P < 0.001$
Belief in physical etiology	3.9	3.8	$F(1,396) = 0.72$, ns
Belief in psychosocial etiology	5.1	5.6	$F(1,390) = 28.19$, $P < 0.001$
Belief in medical treatment	2.7	2.3	$t(411) = 2.01$, $P < 0.05$
Belief in psychosocial treatment	5.5	6.2	$t(411) = 4.45$, $P < 0.001$
Belief in positive prognosis	6.4	6.6	$t(411) = 1.91$, ns

^a All scales are reported as seven point scales wherein a higher number indicates a stronger perception or belief.

The greater social acceptance being shown by female adolescents does, therefore, seem to specifically reflect their reactions to mental illness, rather than a generally greater social acceptance of all people. The sex of respondent \times sex of target person interaction indicates a tendency for the difference between male and female respondents to be greater with reference to male than female target persons.

Examination of other components revealed that male and female respondents did not differ in their belief in the physical etiology of mental illness. They did, however, differ in their belief in psychosocial etiology ($F(1,390) = 28.19$, $P < 0.001$). Females rated social causative factors as more important than males in determining the particular behaviours portrayed in all the vignettes (mean ratings were 5.6 and 5.1 respectively). There were no other main or interactive effects on social etiology.

Male and female respondents differed in their attitudes toward both medical and psychosocial treatment. Just as female adolescents believe more strongly than male adolescents in psychosocial etiology for the behaviour described, so too they indicated a stronger preference for psychosocial treatment ($t(411) = 4.45$, $P < 0.001$). Males, on the other hand, showed a marginal tendency to believe more strongly in medical treatment ($t(411) = 2.01$, $P < 0.05$).

It appears, therefore, that female respondents' greater social acceptance of the mentally ill may be related to their greater belief in the psychosocial etiology of mental illness and in the efficacy of psychosocial treatment. It may be that the importance females attach to the psychosocial dimensions of mental illness results in their being more concerned than men not to foster the social isolation of the mentally ill. Certainly, it does not appear that the difference between males and females in preferred social distance toward those who show disturbed behaviour can be related to other components such as perception of severity of mental illness, or more optimistic beliefs about prognosis.

Conclusions

The growth of community and social psychiatry has necessitated a greater understanding of various aspects of public beliefs about and attitudes toward mental illness. It has become particularly important to influence these beliefs and attitudes toward mental illness in the direction of greater social acceptability and an overall positive view regarding prognosis. Our findings have some relevance to and implications for this aspect of social psychiatry.

The data we have reported suggest that for adolescents a belief in psychosocial etiology and treatment is more positively related to expectation of good prognosis for the mentally ill than is belief in physical etiology and/or medical treatment. Also, while belief in the importance of psychosocial treatment is positively related to social acceptance of the mentally ill, belief in medical treatment tends to have the opposite relation to social acceptance. Clearly such relationships are important considerations in the development of any strategy to educate the public about mental illness. It would seem that in order to encourage optimism about and acceptance of the mentally ill, one needs to either emphasize the psychosocial aspects of mental illness or present the medical aspects in such a way that they encourage more positive social attitudes toward the mentally ill.

Related to these observations is the additional finding that differences between males and females in the social acceptance of the mentally ill may be related to differences in beliefs about psychosocial etiology and the advisability of psychosocial and medical treatment for the mentally ill.

The bases of the relationships found between varying aspects of attitude towards mental illness awaits further clarification. What is there, for instance, about belief in psychosocial etiology and treatment that would cause it to be more positively related to optimism about prognosis than is belief in physical etiology or medical treatment? As with most correlational findings, there are a number of conceiv-

able explanations for these relationships. One possibility is that psychosocial factors are perceived as being more flexible than medical conditions and therefore recovery is seen as more likely to occur. Valins and Nisbett (1972) have suggested that if emotionally disturbed individuals can attribute their undesirable behaviours to external causes (which could include some psychosocial factors) as opposed to internal factors (including medical conditions) they may be more optimistic about their own prognosis. Perhaps a similar dynamic may occur for outside observers of disturbed behaviour. A number of highly tentative speculations could be made, but real clarification of these relationships will require further empirical research.

A final issue which must be addressed concerns the extent to which findings based upon an adolescent population will generalize to other age groups. Do adults show a similar pattern of interrelationships between components of attitudes toward mental illness? It has been found that adolescence is a critical stage in the development of attitudes towards politics, religion and morality (Adelson 1975; Fowler 1976; Kohlberg 1976); and it may also be a discrete phase in the development of attitudes toward mental illness. Keniston (1975) has suggested that post adolescent period of youth may bring an increase in a person's ability to see more subtle similarities and dissimilarities between oneself and others who are from different backgrounds, groups, etc. Such changes could effect one's ability to empathize with people displaying disturbed behaviour and in turn influence attitudes toward mental illness. The possibility that such post-adolescent changes do occur suggests the importance of further research on the generalizability of the current findings to an adult population.

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Ross M.G. Norman
Division of Community Medicine
Memorial University of Newfoundland
St. John
Newfoundland
Canada A1B 3V6

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